Virginia HIV Community Planning Committee

2003 Comprehensive HIV Prevention Plan

Submitted to the Virginia Department of Health

Table of Contents

I. Description of the Epidemiologic Profile

The Statistics and Data Management staff of the Virginia Department of Health Division of HIV/STD prepared the Virginia HIV Community Planning Committee's (HCPC) Epidemiologic Profile of Virginia. Development of the report was accomplished in conjunction with the Ryan White Subcommittee of the HCPC. The profile includes HIV/AIDS, STD and teen pregnancy data. Trends and rates by race/ethnicity, risk, age, region and gender are provided as well.

The Epidemiologic Profile is printed as a separate document. However, it is a significant part of the plan. The priority populations established by the HCPC closely follow the populations most affected by HIVAIDS in Virginia.

For a copy of the profile that accompanies the 2003 Comprehensive Plan, please call the HIV/STD/Viral Hepatitis Hotline 1-800-533-4148 (in Virginia only) or the Hotline Office at (804) 225-3736.

II. Target Populations

During spring 2001, the HIV Community Planning Committee began the process of reprioritizing populations. This activity was last undertaken in 1998 during year one of the three- year planning cycle.

The HCPC reviewed the process used in 1998 including the formula which consisted of three year incidence of HIV and AIDS cases, a risk factor score derived from the San Francisco Community Planning Group, size of the population, and a need factor score derived from HCPC member rankings of needs identified through an organizational survey.

Risk

.4 (% of HIV cases) + .4 (% of AIDS cases) + .2 (relative risk factor score)

Need

.3 (% of total population) + .15 (% of HIV cases) + .15 (% of AIDS cases) + .4 (relative need factor score)

Score

.6 (risk score) + .4 (need score) = population score.

In 1998, six populations were ranked using this system and persons living with HIV/AIDS (PLWHA) were added to the list to create seven prioritized populations. PLWHA were not included in the ranking process due to the difficulty of applying the formula used; however, the HCPC considered primary and secondary prevention services for this population vital and included them in the seven overall priority populations. In addition, the HCPC identified three populations of "special interest": the homeless, persons who sell or trade sex, and the mentally ill/mentally retarded. The HCPC was unable to find either sufficient or reliable data on these populations to include them in the target population prioritization but felt their risk for HIV, based on environment and circumstance, warranted inclusion in the process and would highlight the need to include these populations in outreach and other interventions. The populations in rank order from 1998 were:

1998 Priority Populations

Racial/ethnic minorities
Men who have sex with men (MSM)
Women
Injecting drug users (IDU)
Youth
Inmates
Persons with HIV/AIDS

Populations of Special Interest

Homeless
Persons who sell or trade sex
Mentally ill/mentally retarded

After reviewing the 1998 process, the HCPC discussed possible changes to the formula. During the next two meetings, the Statistics and Data Management Staff of the Division of HIV/STD presented HIV data to the HCPC and discussed trends in the epidemic. The information presented is included in the current epidemiologic profile. These data confirmed that the priority populations established in 1998 still constitute the core of the 2001 prioritization process. In addition, VDH prepared a chart for each of the populations under consideration using the following:

- three year HIV incidence
- 1990 and 2000 Census data
- national seroprevalence estimates
- three year chlamydia, syphilis and gonorrhea incidence

In addition, HCPC members were provided with the San Francisco Relative Risk Factor Table and population-based unmet need scores from the most recent organizational needs assessment. Discussion was held regarding both finalizing populations to be prioritized and inclusion of data elements.

Women versus Heterosexual Category

During the last two planning cycles, women were included as a priority population while heterosexuals were not. Discussion ensued regarding a change in category from women to heterosexuals. Arguments for changing to heterosexual included:

1. Heterosexual most closely defines a risk behavior and is easier to align with CDC risk categories.
2. The category of women leaves out men who are engaging in heterosexual activity and perhaps transmitting HIV to their partners. The inclusion of men in a heterosexual category may also help target men on the "down low" who engage in sex with men but do not identify as gay or bisexual. These men frequently have female partners who do not know about their risk factors. These men may not be reached with prevention efforts targeting gay and bisexual men.
3. By using the broader category of heterosexual, responsibility for prevention and safer sex is placed on both the male and female partner. By targeting only women, men have not been included in the prevention process, leaving responsibility for condom use, negotiation etc. solely to the female partner.

Arguments to keep women as a distinct category included:

1. The need for intensive interventions for women may be diluted or lost if included in the larger heterosexual category.
2. The heterosexual category does not include women who have sex with women.
3. Women need specific interventions apart from men.

After extensive discussions, the HCPC concurred to change to a heterosexual category with the understanding that women will continue to constitute the primary focus within this category and that women only interventions will continue to be provided.

Transgender

HCPC members proposed that transgendered persons be included in the populations of special interest. Although HIV incidence and prevalence data on these individuals is scant, the HCPC believed that transgendered persons are at increased risk for HIV and are in need of specialized, culturally competent services. Injection of street-purchased hormones; exchange of sex for money or drugs and a history of discrimination from health care and other service providers make these individuals vulnerable to HIV. The Committee voted unanimously to include this population.

Quantification of the Formula

The use of STD data was dropped from the formula because we were unable to obtain Virginia specific data for MSM, IDU and people living with HIV. We were also unable to locate scientific literature providing national or other estimates. In addition, while both HIV and AIDS case data was used in the last prioritization, the HCPC voted to use only HIV data in this process. Virginia initiated reporting for HIV in July of 1989. Eleven years of data collection provides a substantial base for tracking trends etc. Although HIV report data reflects those people who seek out testing and may not include others who are infected, the HCPC believes this data to be more useful than AIDS data that reflects risk behaviors that took place a decade or more prior to reporting. The HCPC utilized data from the past three years to give a current picture of HIV that would not be greatly affected by unusual trends in any one year of reporting. For each population, the percentage of three-year incidence in HIV cases was calculated.

The percentage of the general population comprised by the target population was used to consider size of the population in need of services. For example, while many IDUs may be at high risk for HIV, they comprise a much smaller proportion of the population than do women. However, not all women are at risk. The combination of relative risk behavior and population size was used to balance these factors.

In determining the relative need factor score, the HCPC used the Relative Risk Rates Chart from the San Francisco Community Planning Group.

San Francisco Relative Risk Rates

Act	Relative Risk
Sharing unsterile needles	12
Anal receptive intercourse	9
Vaginal receptive intercourse	3
Vaginal insertive intercourse during menses	2
Anal insertive intercourse	2
Vaginal insertive intercourse	1.5
Giving fellatio	1
Giving cunnilingus during menses	1
Giving cunnilingus	0.5
Other blood to blood transmission	0.5
Getting cunnilingus	0.1
Getting fellatio	0.1
Sharing unclean sex toy	0.1
Vaginal to vaginal contact during menses	0.002
Vaginal to vaginal contact	0.001

By group consensus, the four most common risk behaviors for each population were selected, averaged and converted to a 100-point scale to arrive at a relative risk factor score. When consensus could not be reached, research and journal articles on sexual behavior were utilized to arrive at a final selection of behaviors.

For the first time in prioritizing populations, prevalence estimates were used in determining a population's need. Estimates were primarily acquired from the Centers for Disease Control and Prevention and surveillance reports.

Finally, a rating of unmet needs of each target populations was taken from the most recent organizational needs assessment of Virginia HIV prevention and care providers.

Data Set Used in 2001 Virginia HIV Prevention Population Prioritization

Population	Seroprevalence Estimates (National)	Relative Risk Factor (RRF)	% of 2000 Virginia Population	% of VA 3 Year Incidence	Relative Need Factor (RNF)
Racial/Ethnic Minorities	0.65	15.4	28	49	15.45
MSM	14	10.6	2.5	22.5	13.56
Heterosexuals	0.05	5.4	93	15.6	13.92
IDU	14	15.4	2	11.5	13.71
Youth 13-24	0.5	9.2	17	10.4	14.28
Inmates	2.3	22	0.7	4.9	15.86
PLWH/A	100	22	0.3	100	13.21

Members selected the following formula for use in prioritizing populations:

Risk = .6(HIV seroprevalence) + .4(relative risk factor)

Need = .2(% of population) + .4(% of 3 year HIV incidence) + .4(relative need factor)

Score = .7(Risk) + .3(Need)

For the final ranking, scores were rounded to the nearest whole number.

2001 Priority Populations

Population	**Score**	**Rank**
Persons living with HIV/AIDS	62	1
Racial/Ethnic Minorities	14	2
Injecting Drug Users	13	3
Men who have Sex with Men	13	3
Heterosexuals	11	5
Inmates	10	6
Youth	7	7

Populations of Special Interest (not prioritized)

Transgendered persons
Homeless
Persons who sell or trade sex
Mentally ill/mentally retarded

Brief Descriptions of the Target Populations

Prior to 1998, the HCPC had included sub-populations within each of the identified populations. This method of including sub-populations proved to be problematic in the administration of Requests for Proposals (RFPs) because of the overlap and confusion about who exactly was being targeted by funded interventions. Additionally, the ongoing work of the Survey and Evaluation Research Laboratory to create a database of outcome evaluation studies for specific interventions with specific populations could provide sufficient information for each of the sub-populations to prove useful in prioritizing either populations or interventions.

The HCPC debated the utility of such categorizations, and decided in 1998 that each population as identified shares salient characteristics that help to define specific aspects of prevention interventions and strategies from a theoretical and empirical basis. The HCPC voted

to eliminate sub-populations, and to replace them with brief descriptions of each identified population that highlight the primary characteristics of each population.

While the members recognized that there is significant overlap among populations, the HCPC also decided that to the extent that individuals fall into more than one population category, the need for prevention services correspondingly increases. Overlap also increases the likelihood that such individuals will receive prevention services that meet the various aspects that place them at risk and in need of services. Therefore, it is desirable to be left with these overlapping categories, since those most in need would presumably receive the most services.

During the 2001 prioritization, the discussion of sub-populations was raised again. Within each population, there are individuals who are at higher risk than others. Some categories, such as racial ethnic minorities, do not define a risk behavior but rather a population characteristic. The HCPC decided to reinstate sub-populations to better define those most in need of services within each category. Below are the priority populations and accompanying descriptions. Subpopulations are not in any specific rank order and should be considered a guide to better targeting of the overarching population.

Persons with HIV/AIDS

Because these individuals are already infected with HIV, continuing risky behaviors potentially places themselves at risk for sexually transmitted diseases, possibly acquiring a different or resistant strain of HIV and may place others at risk for infection. The need to learn their HIV status, reduce risk behaviors and access early intervention services highlight the importance of both primary and secondary prevention for this population.

Sub-populations

Sex Workers

Multiple sex partners, including those who do not want to use condoms, present a risk for acquiring STDs, re-infection with HIV and for transmitting HIV to their partners. It may be difficult to assist these individuals in leaving the sex trade if they have few alternatives for employment or are actively using drugs. Women sex workers who are pregnant may risk transmitting the virus to their child. Transgender sex workers have typically had negative experiences in trying to access systems for health care and support. They may see themselves as having limited opportunities for mainstream employment due to their status.

Racial/Ethnic Minorities

Racial/ethnic minorities, specifically Blacks, constitute the largest population of people living with HIV. Lack of support from family, friends, and religious institutions as well as a lack of trust of the health care service delivery system makes these individuals vulnerable to hiding their disease and not accessing prevention, support and care services. Denial of illness may be high and

socioeconomic factors may restrict assess to services. A lack of knowledge of public prevention and care services (especially the AIDS Drug Assistance Program) may lead to a fatalistic attitude that "nothing can be done" and result in increased risk-taking behaviors.

Persons in Denial and/or with other Psychosocial Issues

Fear, anger and the inability or unwillingness to accept a diagnosis of HIV infection may result in individuals being lost to follow up and care. These individuals may continue or increase HIV risk behaviors that can transmit the virus to others. Individuals with mental illness, little education or impaired cognitive functioning may lack the ability to understand what their HIV status means, especially if they have no outward signs or symptoms of illness. Non-compliance with medications can lead to the spread of drug resistant strains of HIV and harm to the client.

Racial/Ethnic Minorities

This category includes individuals whose race, ethnicity, or cultural background is distinctly different from the dominant race or culture. This population includes African Americans, Hispanics, Asian/Pacific Islanders, Native Americans, African immigrants and others. While there are many diverse populations within this category, what distinguishes them is the extent to which their language, cultural traits, and family patterns set them aside from the dominant culture.

Sub-populations

African American substance abusers

Substance abuse has had devastating and far-reaching effects upon African American communities. Racism, poverty and lack of adequate public drug treatment slots have resulted in a disproportionate impact of alcohol and other drug use among African Americans. Because substance abuse may lead to lowered inhibitions, impaired judgment or exchange of sex for drugs or money, risk of acquiring HIV is increased even without the sharing of injection equipment.

Recent immigrants

Virginia, especially Northern Virginia, is a destination for many immigrants including African immigrants. Over 150 languages have been identified as the primary language among Northern Virginia school age children. In some households, the adults do not speak English. Children often serve as interpreters, which is neither practical nor ethical in medical situations. In addition, migrant populations on the Eastern Shore and Northwestern region of the state pass through Virginia each year for apple picking and other agricultural work. In

recent years, growing Hispanic communities have settled in Galax, Rockingham county and the Eastern Shore to work in the poultry processing industry. Language and cultural barriers, immigration concerns, and lack of knowledge of the service system prevent many immigrants from accessing prevention and care.

African American and Latino gatekeepers in faith communities

Churches and other faith institutions continue to serve as spiritual and cultural centers of many African American and Latino communities. Faith institutions offer a unique opportunity to educate individuals not reached through other methods of outreach or interventions. In addition, faith institutions can influence community norms and values around HIV, making systemic changes in adoption of risk reduction behaviors, testing, and entrance into care possible. The trust and buy-in of the gatekeepers (ministers, lay leaders etc.) is necessary to accessing these populations.

Injecting drug users (IDU)

Members of this population use drugs by method of injection, either currently or in the past. This population is not limited to opiate users, since other drugs, such as cocaine and methamphetamine are also injected. Because of the illicit nature of drug use and the particular risk that sharing needles and works presents, this population can be difficult to reach and to engage in ongoing intervention practices.

Sub-populations

New injectors (injecting 1 year or less)

New injectors represent the greatest opportunity to intervene before the individual acquires HIV, hepatitis B or hepatitis C. Because these individuals are often initiated into injecting by an older, experienced user, they may be sharing works with people who have already acquired these infections. New injectors also have not previously received prevention messages about reducing risks when shooting drugs.

Other substance users not in treatment

Although not IDU, other substance abusers such as crack cocaine users are at increased risk for HIV. Cracks and sores around and inside the mouth caused by hot crack pipes and increased rates of ulcerative and other sexually transmitted diseases from exchanging sex for drugs put these individuals at higher risk than the “general population”. Because these individuals are often encountered in similar settings and areas as IDU, efforts to target these individuals can be incorporated into programs targeting IDU.

IDU in Aftercare

The need to support IDU in aftercare programs and assist them in maintaining abstinence from injecting or safer injecting behaviors is often overlooked. As these individuals return to the environments and communities in which they used drugs, prevention interventions should be provided to offer reinforcement and support.

Sex workers

IDU who support their drug habit by engaging in sex for money or drugs are at risk from both their sexual activity and drug use. This category overlaps with a population of special interest.

Men who have sex with men (MSM)

This population includes men who self-identify as "gay" or "bisexual," as well as those who do not so identify, but who engage in sexual activity with other men. The most salient factor within this population involves the way in which their sexual behavior sets them aside from the dominant sexual culture. In many ways, this results in the attachment of stigma that prevents these men from readily accessing services. Additionally, diverse interests and backgrounds bring MSM to identify with and participate in a variety of subcultures that may have limited cross reference.

Sub-populations

Down Low Men

Down low men (men who engage in sex with other men but do not identify as gay or bisexual and may have a primary relationship with a woman) are invisible to each other and to providers of outreach and services making them difficult to reach. In routine work and life DL men are likely to associate with the dominant social and sexual culture. Epidemiology suggests that DL men are a significant avenue for HIV transmission to heterosexual women. These men are unlikely to attend HIV prevention programs targeted to MSM.

Racial/Ethnic Minorities

Diverse cultural beliefs shape personal, family and social life that may help or hinder outreach, provision of services and acceptance or resistance to interventions. Cultural values affect whether or not MSM are acknowledged and receive support. Culturally sensitive providers are vital, yet not widely available, to overcome social stigma and to enhance the capacity of the community to respond effectively.

Substance Abusers

Alcohol and other drugs are widely used and abused among MSM for many reasons including self-medication for depression, low self-esteem and as a way to lower inhibitions. Alcohol has been prominent in the dominant social culture of MSM at bars, clubs and parties. In certain subcultures, prevalence of multiple substance abuse is high, substance use coincides with sexual activity, and is often perceived as integral and important to the sexual encounter. Substance abuse may lead to a disregard of safer sex practices or a reduced ability to make sound judgments and negotiations. Few providers are aware of the substances being used by their clients and many MSM are not likely to discuss their use, abuse or request referrals to treatment. Therapeutic environments for substance abuse are often not sensitive to and sometimes hostile to MSM.

Young Men

Establishing self-identify and experimentation are aspects of youth. The spectrum of experimentation toward self-identity may be broad, producing bisexual, transgender and questioning behavior. Nonjudgmental and comprehensive education on these issues is rarely available. At the same time, the internet has provided access to helpful information while also providing the means for easy and risky opportunities to experiment with both sex and use of drugs and alcohol.

Heterosexual

This population includes both men and women who engage in sexual activity with members of the opposite sex. Epidemiological data has demonstrated conclusively that women are at increasing risk of HIV infection. Other research has suggested that this is due, at least in part, to power imbalances in the relationships between men and women. Some men, who identify as heterosexual, engage in sexual activity with men and women but do not identify as gay or bisexual. These men may only be reached through programs targeted to heterosexuals.

Sub-populations

Persons with multiple sex partners

These individuals are at increased risk for a variety of STDs that may also facilitate HIV transmission. They may have an inability or reluctance to negotiate safer sex and not recognize the consequences of their sexual behavior. Self-esteem, image, and an inability to recognize triggers that lead to sexual encounters such as loneliness, use of alcohol or drugs etc. may contribute to their risk taking behaviors. Persons who practice serial monogamy may not recognize they are at risk.

Persons with STDs

Persons with an existing or untreated STD are at greater risk for STDs due to a compromised immune system and easy access for the virus to enter their bodies, especially among persons with genital ulcer diseases. Persons who present for treatment provide a strategic opportunity for intervention as they have sex without barrier protection and either the individual or a partner has had more than one sexual partner. Persons who have not accessed treatment need to be brought into STD services and offered counseling and testing for HIV.

Racial/Ethnic Minorities

Social economic disparities among Racial/ethnic minority populations may prohibit accessing of the health care service delivery system. Religious and cultural norms (especially among Latino and Asian Pacific Islanders) present barriers to open discussion about sexuality between men and women. In African American communities, being a teen mother can be seen as a status symbol. These girls often date older men and seek status and connection with the father. This cultural norm encourages risk-taking behavior. There is a stigma associated with men of color seeking HIV prevention services for fear of being labeled gay. Programs that target "heterosexual" men are important, as they may be the only venue for reaching bisexual men or men on the down low who would not participate in prevention programs for men who have sex with men.

Women Having Sex with IDUs

These women may not be aware of their HIV risk if their sex partner hides his drug use. They may have a false sense of security because they are having sex with one partner. If they are aware of their partners drug use, they may believe that he is cleaning his works or not sharing works. They may be reluctant to acknowledge their partners risk behavior due to the stigma attached in injecting drug use. In addition, these women may be unable to detect signs of relapse in a person who had stopped using.

Inmates

Individuals in this population are either currently incarcerated or are actively enrolled in the probation and parole systems. These individuals are at particular risk because the very behaviors that placed them in the criminal justice system often also places them at risk for HIV infection, and because they may engage in behaviors while incarcerated that place them at even higher risk. Their need for prevention services is heightened by their lack of access to such services due to constraints enforced by correctional systems.

Sub-populations

Youth offenders

Youth, in general, are more sexually active, are vulnerable to peer pressure, and tend to be more willing to participate in experimental behaviors that place them at risk for HIV infection. Being incarcerated, these youth miss out on the HIV prevention education opportunities available in schools.

Recently Released (6 months)

Because of the lack of community support, inmates have particular difficulty transitioning back into their communities. The longer the incarceration, the more difficult the transition. Newly released inmates frequently become more sexually active and increase their drug use as a way of compensating for "lost time". Reaching individuals who have been released six months or less provides an opportunity to intervene with HIV prevention methods that cannot be implemented in jails and prisons because of institutional restrictions.

Substance Abusers

Due to the national war on drugs, the criminal justice system has experienced a tremendous increase in the incarceration of substance abusers. These individuals bring behavior patterns that place them at risk for HIV infection into the jail or prison setting. These behaviors include needle sharing and exchanging sex for drugs that they continue to practice while incarcerated. Incarcerated substance abusers have higher HIV seroprevalence than other inmates.

Women

Women are being incarcerated in higher and higher numbers, primarily for drug-related offenses. Incarcerated women have a higher HIV seroprevalence rate than do incarcerated men. Most post-release programs and services are designed for men, making them less appropriate or acceptable for women. Because of their relatively shorter sentences, many women released from jail and prison are of childbearing age. Prevention and care issues for these women combined with the need to prevent perinatal transmission make them a key target population.

Youth

This population includes all individuals roughly under the age of 25. While the primary segment of this population includes those under the age of majority, adolescent issues persist into the early 20s. In Virginia, one of the most salient factors of this population is the difficulty of reaching students, due to the need for parental approval in many cases and the lack of cooperation of schools to provide sexually related information to students.

Sub-populations

Youth who engage in survival sex

Youth may engage in survival sex for a variety of reasons. They may be homeless, having run away from home or been forced to leave. Emotional, physical or sexual abuse and sex may be used to trade for food, a place to sleep for the night, or drugs. Adults taking advantage of their situation may coerce them into prostitution. Gang initiation may include being forced to have sex with other gang members. Transgender youth (MTF) may engage in survival sex because they do not possess or are unaware of their skills, or because they cannot get a job due to their appearance.

Substance abusers

Testing limitations and rebelling against parental authority, youth may take risks and experiment with drugs and alcohol. Youth may have easy access to these substances because of a family members use, lack of parental supervision or because of running or trafficking for dealers.

MSM

Young MSM do not receive specific HIV and STD relevant prevention messages through formal education settings. Homophobia and fear of being outed may lead them to have anonymous sexual encounters or they may engage in relationships with older men (someone outside of their social setting). Because they have had little opportunity to engage in dating and relationship rituals in which heterosexual youth participate, young MSM may not have the opportunity to develop communication and negotiation skills around sex.

Racial/Ethnic Minorities

The issues that affect adult members of these populations also affect youth. These factors include racism, lack of trust in the health care service delivery system, a fear of doctors, language barriers, a lack of cultural competency among prevention and care providers, religious and cultural barriers to the discussion of sexuality, reproductive health and HIV, and low socioeconomic status that can limit access to services. In some cultures, fathering a child or giving birth confers status and attention. Young people may engage in unprotected sex to become parents. Other cultures place a high value on virginity, leading young people to engage in even riskier activities such as anal sex.

Transgender

Transgender is a term used to describe individuals who have persistent and significant discomfort with their assigned gender (White & Townsend, 1998). Transgender individuals were born biologically male or female, but live their lives to varying degrees as the opposite gender. A transsexual is a transgender individual who seeks genital reassignment surgery. Not all transgender individuals are seeking to "transition" through hormone therapy, aesthetic surgery or genital surgery; in fact, many do not. Survival sex, sharing needles to inject hormones, lack of sensitivity from providers that discourages transgendered persons from seeking heath care or prevention services, and low self-image that may increase sex and drug-related risk behaviors all contribute to heightened risk for HIV among these individuals.

Homeless

This population includes persons who are either permanently, temporarily or periodically without a residence or shelter. Homeless persons have proven to be difficult to reach for a whole host of vital services. Because of the very high prevalence of mental illness, substance abuse, and prostitution among the homeless, the risk of HIV infection is remarkably high. However, their lack of stability and the culture of the street make it most difficult to reach them.

Persons who sell or trade sex

This population includes both those individuals who market their sexual services for money or drugs (i.e., those who have been termed commercial sex workers) and those who may have sex with only one or a very few number of individuals in order to obtain a wide range of benefits. This latter group includes women or youth who feel compelled to have sex with someone who provides housing or food, for example. Because these individuals often feel at the mercy of the "purchasers" of their services, they engage in behaviors that place them at risk for HIV infection. Because of the illegal nature of the behavior, particularly of commercial sex workers, they often do not trust those who approach offering beneficial services.

Mentally ill/mentally retarded

Because of their illness or limited cognitive abilities, these individuals often lack the social skills necessary to negotiate sexual and other relationships in ways that maintain their safety from HIV infection. These individuals are also significantly more likely to be incarcerated when not receiving proper treatment, placing them in situations and settings they are ill equipped to negotiate.

III. Needs Assessment

Needs assessment is a process for obtaining and analyzing information to determine the current status and service needs of a defined population or geographic area. This process requires obtaining information about current conditions, including problems or service needs, and the resources and approaches that are being used to address these needs. The resulting information is used to establish priorities regarding service needs and to develop strategies for addressing them.

Virginia HCPC strategies to collect information:

- An HIV prevention and care survey completed by AIDS Service Organizations (ASO's) and other service providers across Virginia.
- Public Hearings held in each of the five health regions during November 2001.
- Member expertise
- Epidemiologic Profile
- VDH statistical data from HARS

Public Hearings

The public meetings were held in each of the five health planning regions in the Commonwealth of Virginia. The information gathered will be used by HCPC's for future decision-making regarding prevention and care services. Included on the panels were a member of HCPC who served as a regional representative, a Ryan White C.A.R.E. Act representative, and the Director of Community Services to answer questions the public addressed. The purpose of the meeting was to gather public input from citizens who express their opinions on HIV/AIDS prevention and care.

Roanoke, November 8, 2001

The Roanoke Valley is western Virginia's center for industry, trade, health, education, travel, conventions, and entertainment. Roanoke lies west of the Blue Ridge Mountains and midway in the "great valley" between Maryland and Tennessee.

Roanoke's population for 2000 census was 94,911. The majority racial group is white at 69.4%. African Americans are the second largest group, having increased to 26.7% in 2000. Hispanics and Asians represent less than 5% of the population; however, these groups are expanding in terms of percentage growth. Between 1990 and 2000, the population has increased 5% in the metropolitan area.

In the VDH September 30, 2001 Surveillance Quarterly, the cumulative number of reported HIV cases was 416, and reported AIDS cases was 380. The majority of new HIV cases were among African-American MSM in the age group of 20-39; and the majority of reported AIDS cases were among white MSM males in the age group of 20-39.

A total of 12 people attended this public hearing including providers, clients and caregivers. Several health care staff were disappointed that there was not a larger client turn out. Several individuals indicated to them that they were interested in attending but were fearful to do so because of the ongoing and pervasive stigma in rural areas of Virginia.

Representatives from the West Piedmont AIDS Taskforce in Martinsville addressed a variety of prevention and care issues and the struggle to obtain even minimal services in a rural setting. Issues noted include:

- **Lack of primary care physicians for HIV positive clients.** All 24 clients in their area must travel to Roanoke VA, Winston-Salem or Durham NC for care. WPATF would like to have an Infectious Disease Specialist to visit locally, even if only once a month.
- **Inadequate transportation.** Only four clients have transportation and it is difficult to arrange volunteer transportation on short notice. Clients frequently miss their medical appointments.
- **Inadequate phone service for clients.** Only five of the 24 clients have phone service.
- **Lack of preventative dental care.** Currently service providers are only able to reimburse for therapeutic dental care. Service providers would like all Ryan White Title II consumers to be allowed one annual routine care and cleaning dental visit.
- **Need for nutritional supplements.** Currently must wait for prescription to distribute. Prefer to hand out supplements at own discretion. Service providers would like a daily multivitamin included as allowable expense.
- **HIV/STD prevention**. Many people in the area believe AIDS/HIV/STD's are "big city problems" and they are not affected by it. There is a need for more prevention education funding in the area. Prevention education efforts are also hindered by "abstinence-only" agendas of many churches and school groups. They do not allow condom distribution, or even mention of condoms.
- **Community attitudes.** Many clients are reluctant to use the services available through WPATF because of repressive attitudes in the region to HIV/AIDS and fear of disclosure of their HIV status.

Clients and caregivers from the Roanoke area expressed concern about the following issues:

- **There continues to be high levels of discrimination around HIV in the region**.
- **There are few support systems or services.** Currently there is only one support group in Roanoke. This is a closed group that is not taking new members. Support and counseling for family members and respite care for caregivers are also needed. Childcare and women's services are lacking.
- **Resistance/negativity from churches and preschools.** We need to get the message into these places that AIDS affects all of us, not just certain populations.

- **Inadequate health care.** It is difficult to find and keep qualified staff including phlebotomists and health care aides. Nurses are often not adequately trained to deal with HIV. There are no minority providers in the area, which can be a barrier for some people seeking care. There are no OB/GYNs in many areas and no adolescent specialists.

- **Capacity building for agencies.** Most ASOs in Southwest are not equipped to compete for funds. We need to build their capacity to secure funding and provide them with training to carry out prevention and support services.

- **Clients face complex issues and institutional barriers.** Families of persons with HIV often cannot pay for funerals and are turned away from traditional helping organizations such as churches. Clients with felony convictions cannot qualify for public housing.

- **Need for adolescent services.** There is a need to conduct outreach for sexually active teens. As children born with HIV are now reaching their teen years, counseling regarding sexual activity needs to be provided.

Chesterfield County, November 15, 2001

Chesterfield County is part of the Richmond-Petersburg MSA and is bounded by the cities of Richmond, Petersburg, Hopewell, and Colonial Heights. Situated between the James and Appomattox Rivers, Chesterfield's land area totals 446 square miles and consists of a pleasant mix of suburban communities that are within a two-hour drive of Virginia beaches, the Blue Ridge Parkway and Washington D.C.

According to the 2000 Census, Chesterfield accommodates 259,903 people, a 24.0% increase compared to the 1990 Census. The majority racial group is that of whites at 76.7%. African Americans have increased to 17.8% in 2000. Hispanic and Asian-Americans, although a smaller group in terms of numbers, are rapidly expanding in terms of percentage growth.

In the VDH September 30, 2001 Surveillance Quarterly, Chesterfield's cumulative number of reported HIV cases was 314 and AIDS was 361. The majority of new HIV cases were among African-American MSM and IDU's in the age group of 30-39, and the majority of reported AIDS cases were among African American MSM in the age group of 30-39. Fifteen individuals attended including ASOs, clients and care providers. Comments included:

Mass media campaigns. HIV is losing visibility and we need more money to support radio, billboard and bus advertising.

- **Aftercare and counseling for youth offenders when released from Juvenile detention centers.** Programs for youth sex offenders should be re-established. This would help reduce the risk of repeat offense. There is a need for continued contact with counselors. (The DJJ representative noted that after youth are released, they do not have the authority to follow-up with youth in the community.)

- I**nmates of jails and correctional facilities have high rates of STDs.** Neither staff nor inmates have adequate education or training in HIV, STD, hepatitis or TB. Inmates must wait in line for more than an hour to receive medication.

- **HIV testing for inmates.**

- **Need for capacity building and technical assistance.** This is especially vital for minority and newer agencies.

- **Need for HIV programs to be more culturally sensitive and appropriate.** Programs should be delivered by individuals who have developed rapport within communities and venues. Educators should not offend and be "in your face".

- **Central Virginia needs programs for MSM of color.** There is a variety of lifestyles within MSM of color. Many of these men may never interact. Need a variety of programs, approaches and providers to reach different groups. The messenger needs to be appropriate. There are a number of underground MSM gathering spots that have not been reached by traditional outreach to MSM of color.

- **More recruitment is needed for minority care providers and social workers**. Many minority providers do not provide HIV services. VDH should encourage diversity in hiring within health care services and do more to recruit and retain minority providers.

- **Case management is not being effectively provided.** New clients coming into service are not comfortable with the services. Need improved and revised standards and guidelines.

- **ADAP eligibility should be raised from the current 250% of poverty level.**

- **Insufficient education in the schools.** Youth in the 5^{th} and 6^{th} grade are having oral and anal sex to avoid pregnancy.

- **Agencies need to expand funding sources including corporate solicitation and direct funding from CDC.**

- **Single fathers need to know about services such as childcare and transportation.**

- **Concerns about funding distribution.** Participants expressed concerns that certain agencies seem to get all the funding. Participants discussed that quality rather than just quantity of people being reached should be the focus. VDH staff agreed with this thinking. VDH emphasized that funding is also based on results. Agencies that successfully complete objectives, report on time and maintain appropriate administrative oversight, compete well for additional funding. Examples were provided from the OraSure pilot in which results can be easily measured by the number of the target population tested and the number of new infections found. Some agencies received

funding, intensive technical assistance and support but did not complete deliverables. These agencies are not likely to compete well for funds in the future.

- **Need to involve faith-based communities.**

Charlottesville, November 19, 2001

The City of Charlottesville is located in Central Virginia, approximately 100 miles southwest of Washington, D.C. and 70 miles northwest of Richmond, Virginia. Nestled in the foothills of the legendary Blue Ridge Mountains, the area is also known for year round natural beauty and a variety of accommodations, attractions, events, and activities.

In addition, it houses the University of Virginia resulting in a large transient college-age population. According to the 2000-year Census, there were 45,049 people in the small city of Charlottesville compared to Richmond City with a population of 197,790. The demographic make up of Charlottesville is majority 69.6% white, and a rapidly growing population of African Americans (22.2%). The populations of Hispanic and Asians are a smaller, but projected to increase in the near future.

As of September 30, 2001, Charlottesville reported 108 HIV cumulative cases and 142 AIDS cumulative cases between 1989-September 2001. The majority of new HIV cases were among African-American MSM in the age group of 20-39, and the majority of reported AIDS cases in Charlottesville were among white MSM males in the age group of 30-39.

Five persons attended the Charlottesville hearing. The proximity to the Thanksgiving holiday may have hindered participation. Major issues and concerns noted were:

- **Medication Co-pays**. Many people who have insurance still cannot afford their AIDS medications due to high co-pays. The working poor are underinsured. Sliding scales for services and medications are needed. It was noted that co-pay funds for medication were made available this year but the consortia decided to direct these funds to other uses.

- **Income eligibility for ADAP should be raised from the current level of 250%.**

- **ASOs need funds for capacity building and training.** Agencies do not have the computer capacity needed to conduct business. Volunteer management and board development are needed. Agencies need to be informed about existing infrastructure and resources that can support them. Agencies need guidance in learning how to tie into existing infrastructure and resources.

- **Expand HIV/STD web site to include information on all available grants and their grant cycles so providers can have more time to prepare proposals.** Agencies often do not have time to adequately prepare new or innovative programs. Information about the timing of grant cycles would be helpful.

- **MSM of color are difficult to reach in the Northwest region.**

- **More involvement is needed from minority churches.**

- **Establish a revolving fund.** This fund would support ASO activities outside the area of interventions including conferences and training. These funds would support ideas developed outside of the normal grant cycle.

- **Need faith-based or religious brochures.**

Hampton, November 28, 2001

Hampton is a growing community with a population of approximately 146,000. The city is located roughly 75 miles southeast of Richmond, the State capitol, and 175 miles south of Washington, DC. Hampton is an integral part of the nation's 31st largest metropolitan statistical area (MSA) known as Hampton Roads. It is also the fourth largest MSA in the Southeastern United States.

The city is home to Hampton University, a historically Black school on the city's waterfront. The city also boasts a strong military and technology presence. Hampton is closely divided between whites (49.5%) and African-Americans (44.7%). Hampton has expanding Asian and Hispanic populations.

In the VDH September 30, 2001 Surveillance Quarterly, Hampton's reported HIV cumulative cases were 416, and 324 reported cumulative cases of AIDS. The majority of the new HIV cases are among African-American MSM in the age group of 20-39, and the majority of reported AIDS cases in Hampton were among African American MSM in the age group of 30-39.

Thirteen individuals attended this hearing. Prior to the start of the hearing, members of Young Ones United to Help (YOUTH), the Eastern region youth advisory council to the HCPC, presented a skit and a question and answer session. The adults had numerous questions for the youth concerning risk behaviors of their peers, reaction from peers about their YOUTH involvement and their motivation for becoming involved in peer education. Questions and comments follow:

- **Why don't schools provide more information about HIV?** VDH described the role of the Department of Education and the autonomy of each school district to determine its family life education curriculum. There was much discussion regarding the different levels of education allowed by each locality in the Tidewater area as well as frustration about restrictions in many of the schools. The youth were especially vocal about the inadequate amount of HIV and STD prevention education.

- **Youth are using anal and oral sex to prevent unwanted pregnancies but placing themselves at risk for HIV and STDs.**

- **Need to reach heterosexual men.** Heterosexual sex is less risky for men than women. Need to encourage these men to protect themselves and their partners. If in a sero-discordant relationship (female partner is positive), need strategies to convince these men to use protection. It often cannot be an "all or nothing" proposition. Need to strategize what is acceptable risk reduction for each person.

- **Seamless transition program appears to be working well.**

- **Free HIV medication should be provided to all HIV infected persons regardless of their ability to pay.**

- **Need additional work with the faith-based communities**.

Fairfax City

The City of Fairfax is at the heart of Northern Virginia's government and business. Located 20 minutes from Washington, D.C., Fairfax is home to more than 21,000 residents and 29,000 business and government employees, including large companies and small service firms, lawyers and other professionals, thriving retail stores and national trade associations.

According to the 2000 Census, Fairfax accommodates 21,498 people. The majority racial group is that of whites at 72.9%. Hispanics are the second largest group at 13.6%, with Asians following at 12.2%. In contrast to other regions in Virginia, African Americans constitute a small percentage of the Fairfax population at 5.1%. The Northern region has the largest populations of Hispanics and Asians in the Commonwealth.

In the VDH September 30, 2001 Surveillance Quarterly, Fairfax's reported HIV cumulative cases was 62 and 55 reported cumulative cases of AIDS. The majority of the new HIV cases are among African-American men with no identified risk in the age group of 30-39, and the majority of reported AIDS cases in Fairfax were among White MSM males in the age group of 30-39.

Twenty-two people attended this session. This session was more question and answer orientated than strictly comment.

Q- Why aren't HCPC activities better coordinated with Ryan White Title II Care programs?
A- Each of the care consortia has a seat on the Ryan White Subcommittee of the HCPC. These individuals are to serve as the liaisons between the HCPC and consortia. If this is not occurring in Northern Virginia, the consortia should consider appointing a new representative. Recently, HCPC and Ryan White have been collaborating on the organizational needs assessment for care and prevention services. This public hearing is also a joint activity between prevention and care.

Recommendations on collaboration for prevention and care are included in the 2000 Comprehensive Plan.

Q- Why isn't there coordination between SCSN and HCPC?
A- Several HCPC members, who are also part of Title I and II councils and consortia, sat on the advisory committee to plan the SCSN. The Community Co-Chair for HCPC also facilitated one of the SCSN afternoon sessions. (The person who asked the question stated that he did not know who any of these people were).

Q- Why have we never seen the HCPC Comprehensive Plan (red book)?
A- Copies of the plan were mailed to all local health districts, community-based organizations, AIDS service organizations, consortia and regional AIDS resource and consultation centers on the VDH mailing list. Their availability was advertised in the Surveillance Quarterly, which goes out to more than 1,000 addresses, and they were made available at the SCSN meeting.

Q- Why do youth keep getting pushed further down the priority list?
A- Youth continue to be a priority population for the HCPC. Despite little data showing HIV infection in this population, we know adolescents have high STD rates, are prone to taking risks, and may not present for testing. Infections acquired while young may not be picked up until the person is in the 20s or 30s. Youth programs are actually over-funded compared to the level of infection in this population; however, it is important to continue to target this population. Projects targeting populations with the greatest seroprevalence rates (MSM and IDU) are under funded. One goal of the HCPC is to ensure that resources are directed to meet gaps in services for the epidemic.

Other hearing comments:

- **Lack of dental care**. Additional providers are being recruited. There is also lack of availability of non HIV-related medical care for the uninsured. Most local health departments no longer provide general medical services.
- **Transportation.** Although this is a large metropolitan area, travel time back and forth to covered Ryan White providers can take several hours by metro and bus making it very difficult for clients, especially if they are not feeling well.
- **More funding is needed for prevention and care.** Funds should not be diverted away from HIV to support bio-terrorism. (A discussion ensued in which the need for the community to be proactive with their state and federal legislatures to secure funding is needed. VDH does not control the amount of federal or state dollars it receives and cannot lobby for additional funds. This is the role of the community.)
- **Growing diversity in Northern Virginia.** This area continues to grow in diversity of cultures and languages, which provides a challenge to keep up with the need for multicultural materials and bi-lingual service providers. Cultural awareness and competency among prevention and care providers must continue to develop.

New agencies cannot get funding. There was concern from three newly established minority CBOs that VDH will not award funds to new agencies and that all funds go to agencies that are already established. When questioned, however, two of the three agencies indicated they had not

yet applied for any VDH prevention money. VDH staff clarified that funds can only be awarded through the competitive Request for Proposals process. Agencies need to contact VDH to get onto mailing lists so that they can receive notice of funding opportunities. In addition, VDH staff noted that there is about 50% turnover in awards with new RFPs. The same agencies are **not** always funded. New agencies without much organizational history are at some disadvantage in competing. If they have experienced staff, however, they should emphasize this in their proposal. There seemed to be a lack of understanding of how the governmental funding process works.

- **Lack of qualified minority CBOs in Northern Virginia.** With Hopkins House (the largest minority CBO in Northern Virginia) ceasing HIV services effective December 31, 2003, several participants expressed concern about a vacuum of services to reach the minority population. VDH discussed that an RFP had been issued to fund the Northern region AIDS service organization grant. Participants repeatedly asked what agency was being awarded funds. VDH staff explained that the process was not yet complete and the information was not yet public. Several persons stated that "certain agencies" were being funded to do prevention but were not truly out there doing outreach. Participants asked specifically about one organization. VDH responded that it would be inappropriate to discuss the performance of a particular contractor. VDH noted that it had been funding this agency for less than one month and would not yet have any data on their performance. The individuals who raised questions were referred to the funding agencies that currently held contracts with this organization for information on performance.

- **Request to bring back the capacity building grants program and offer more frequent training.**

- **Need for additional minority providers.**

Over-Arching Themes at the Hearings

Overall, major topics brought up at virtually every hearing were:

Capacity building and technical assistance for CBOs,

The need to reach incarcerated populations,

Transportation for HIV-infected clients, and

Funds for medication co-payments.

Additional issues that were frequently mentioned included:

Need for additional mass media campaigns

Recruitment and retention of minority health care providers

Virginia's 2001 HIV/AIDS Needs Assessment Organization Survey

This was the third survey in a series of organization needs assessments that Virginia has conducted with HIV/AIDS service and prevention program providers. Over time, there have been many changes including the organizations involved to the populations that they work with; however, the HIV/AIDS service needs have not changed significantly.

The needs assessment required respondents to answer questions in the following topic areas:

- **Characteristics of Responding Organization:** information about service providers including geographic location, services provided, populations served and technical capacity i.e. computer and internet access
- **Perceived prevention needs:** data collected from providers about the HIV/AIDS prevention needs in their communities
- **Unmet needs:** Prevention services that are needed but unavailable or in need of expanded services in the region
- **Barriers to Services:** perceived barriers to prevention services

Methodology

The Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University designed the 2001 Virginia HIV/AIDS Needs Assessment Organization survey along with input from the Virginia HIV Community Planning Committee (HCPC). A total of 205 organizations, that receive state, federal, local or private funding, were targeted to receive the 2001 HIV/AIDS Needs Assessment Organization Survey. A total of 132 organizations responded to the survey. The survey consisted of questions detailing information on the characteristics of the organization, the prevention services provided and the care services provided.

Each of the five health planning regions was represented in the agencies that responded to the survey. The majority of organizations responding were from the central (37) and eastern (33) regions respectively, followed by northern (26), southwest (22) and northwest (10). Four agencies did not to indicate a region; therefore, those responses are included in statewide responses, but excluded from regional calculations.

Eighty-nine agencies indicated they provided HIV prevention services, with 56% stating they provided HIV prevention and care service. The funding for HIV prevention for these agencies comes primarily from public sources. Overall, the operating budgets for HIV prevention services are generally very low. Most organizations have less than $50,000 directed towards prevention programming.

Findings

General findings from this needs assessment include the following:

Statewide:

- *Caucasians* and *HIV-infected* are viewed as the population with the best-met needs in care and prevention services.
- The *migrant worker population* is viewed as the population most in need of prevention and care services.
- Increased prevention education is needed for *persons with mental health/mental retardation issues* and the *very young (0 – 12) population*.
- Increased care services are needed for *youth offenders* and *persons who sell or exchange sex*.
- Prevention programs and care services are needed for *adolescents* and *African Americans*. Although widely available statewide, there is a need to expand in order to provide more comprehensive services.
- Prevention programs need culturally and linguistically appropriate educational materials.
- There is a need for staff trained in mental health and substance abuse issues.
- The most cited barrier for providers is the cost associated with implementing new programs.
- For consumers, transportation difficulties are the main barrier in accessing prevention and care programs.

Northwest:

- There is a strong need for prevention programs targeting *Asian/Pacific Islanders.*
- Prevention programs for *Hispanics* need to be expanded.
- Northwest area agencies need staff training in working with *substance abusers* and *persons with mental health needs*.
- The number one barrier to programs is finding and engaging specific priority populations in the prevention programs.
- HIV care services are needed for *homeless persons* and *persons who sell or exchange sex*.
- Available HIV care services need to be expanded for *lesbian/gay youth* and *HIV-infected persons*.

Northern:

- Northern needs prevention programs aimed at the *50+ population*.
- Prevention programs need to be expanded for *adult inmates*.
- *Hispanics* and *heterosexual women* need prevention programs expanded.
- Northern area agencies need staff training in working with *substance abusers* and *persons with mental health needs*.
- HIV care services are needed for *youth offenders* and *lesbian/gay youth.*
- Available HIV care services need to be expanded for *young adults (age 18 – 24)* and *adult inmates*.

Southwest:

- Southwest agencies need prevention programs that target *persons who sell or exchange sex*.
- Prevention services for *heterosexual women* need to be expanded.
- Consumer awareness of available programs is a barrier to programming.
- HIV care services are needed for *Asian/Pacific Islanders* and *transgendered persons*.
- Available HIV care services need to be expanded for *heterosexual women* and *HIV-infected persons*.

Central:

- There is a strong need for prevention programming targeting *youth offenders*.
- *HIV-infected individuals, Hispanics* and *Men who have Sex with Men* need expanded prevention programs.
- Educational materials need improvement and revision for presenting information.
- HIV care services are needed for persons with *mental health/mental retardation issues* and *persons who sell or exchange sex*.
- Available HIV care services need to be expanded for *men who have sex with men*.

Eastern:

- More prevention programming is needed targeting *homeless persons.*
- Prevention programs need to be expanded for *young adults, age 20 – 24.*
- HIV care services are needed for *partners of substance abusers, homeless persons,* and *adult inmate*s.
- Available HIV care services need to be expanded for *heterosexuals (female and male), HIV-infected persons* and *partners of HIV+ persons.*

Overall, providers indicated that they are providing HIV prevention and care services satisfactorily in the state; however, more can be done to provide services that are culturally sensitive, educationally sound and reflect the specific needs of the target populations.

For the complete copy of Virginia's 2001 HIV/AIDS Needs Assessment Organization Survey, please contact the Virginia Department of Health HIV/STD/Viral Hepatitis Hotline at 1-800-533-4148.

IV. Resource Inventory

Below is a description of prevention services funded by VDH as of January 1, 2003 as well as those provided through other sources of funding.

Virginia Department of Health Funded Programs

AIDS Service Organization Grants

Purpose: To provide education to the public and populations at highest risk for HIV and support services to persons affected by HIV/AIDS in each of the five health regions. AIDS services organizations (ASOs) strive to reduce the spread of infection and assist those with HIV in securing services and improving their quality of life.

CY 2003 Funding: $635,500

These contractors are required to provided educational programs and outreach to at least four priority populations of the HCPC. Some of the ASOs provide case management, secondary prevention and support services. Populations targeted include Racial/Ethnic Minorities, MSM, Heterosexuals (women), IDU, Inmates, Youth and People Living with HIV/AIDS. Populations of special interest targeted include the homeless and mentally ill/mentally retarded. Rural populations are also a focus in some regions.

Northwest

AIDS/HIV Services Group located in Charlottesville serves as the ASO for the Northwest region. Racial/ Ethnic Minorities, Men who have Sex with Men, and Incarcerated are the targeted populations. Services for these populations include Group Level Interventions, Basic Street Outreach, and Facilitative Street Outreach.

Northern

Located along the I-95 corridor, **Positive Livin'** serves as the ASO for Northern Virginia. Through Group Level Intervention, Prevention Case Management, Presentations/Lectures and Basic Street Outreach Positive Livin' reaches African American, Incarcerated, Persons Living with AIDS (PWA) and Youth.

Southwest

Council of Community Services representing West Piedmont AIDS Taskforce, New River Valley AIDS Coalition, Cohort and Appalachian AIDS Coalition targets African Americans, Heterosexuals, Substance abusers and Youth in the Southwest region of Virginia. Services provided by the group includes Group Level Intervention, Individual Level Intervention, Basic Street Outreach, Facilitative Street Outreach, Presentation/Lectures, and Health Fairs.

Central

Fan Free Clinic serves the Central part of Virginia through Group Level Intervention, Individual Level Intervention and Presentation/Lectures. The populations targeted are African American, Incarcerated, Injecting Drug Users (IDU), Youth and MSM.

Eastern

Tidewater AIDS Crisis Taskforce targets African American, Incarcerated, PWA, Youth, IDU, Heterosexuals, Homeless and Mentally Ill in Eastern Virginia. Interventions provided are Group Level, Presentation/Lectures, and Basic Street Outreach.

Minority AIDS Projects

Purpose: To reduce the transmission of HIV infection among people of color that have been disproportionately affected by the epidemic and to ensure that culturally appropriate prevention education is provided within and by minority communities most affected by HIV and AIDS.

CY 2003 Funding: $845,721

Northern

Alexandria Health Department contracts with Ethiopian Community Development Center (ECDC) to reach African Americans, African immigrants and youth. The Health Department also contracts with Wholistic Family Agape Ministries Institute, which subcontracts with Whitman-Walker Northern Virginia (WWC-No.VA), to reach Latino residents. WFAMI targets Africans and substance users.

Arlington Health Department contracts with Newcomers Community Service Center (NCSC) to deliver culturally specific HIV prevention education to Asian residents in Northern Virginia. NCSC subcontracts with WWC to provide outreach to the Latino population. Also contracted with is the ECDC to provide HIV prevention to African immigrants.

Fairfax County Health Department contracts with Positive Livin' to reach youth and IDUs. Fairfax also contracts with SERAs to conduct outreach to African American and Hispanic MSMs.

Central

City of Richmond Department of Health contracts with the Minority Health Consortium Inc. to provide HIV risk reduction education to women and men in public housing and substance abuse recovery centers.

Petersburg (Crater Health District) contracts with three organizations to provide prevention education services in the Crater Health District. Minority Health Consortium provides HIV prevention education and street outreach in Petersburg, Greenville/Emporia, and Waverly/Sussex. The interventions target MSM, IDU, and the general population. St. Stephen's

Episcopal Church provides HIV risk-reduction education in the Petersburg Public middle and high schools. Victory Christian United Church of Christ provides HIV risk-reduction education to Petersburg area youth.

Eastern

Norfolk Minority AIDS Project contracts with International Black Women's Congress (IBWC) for HIV prevention, risk-reduction education and street outreach in Norfolk, concentrating in public housing developments.

Portsmouth Health Department contracts with the Urban League of Hampton Roads to provide prevention education and street outreach in the city of Portsmouth.

AIDS Services and Education Grants Program

Purpose: To reduce the transmission of HIV infection in hard-to-reach populations through innovative HIV prevention education, support services and outreach. Program provides training for volunteers, community outreach, home health parties, peer education and training, mobile case management services, counseling and support services. State funding for this program began in 1989.

FY 2003 Funding: $200,000

Northwest

AIDS/HIV Services Group provides HIV prevention and risk reduction services to African-American women through multiple session modules using the four-session "Sister-to-Sister" curriculum. These combined sessions address the following topics: sexual negotiation skills; assertiveness training; communication skills; self-efficacy and control; risk-trigger management; peer support for change; HIV transmission knowledge and condom use.

AIDS Response Effort (ARE) provides group level interventions for incarcerated individuals. Information is presented in two 1 ½ -hour sessions covering HIV transmission, risk assessment, behavior modification, substance abuse, triggers, and STD's. ARE periodically provides HIV/AIDS education in-service training to correctional staff.

Central

Virginia League for Planned Parenthood provides a nine-session human sexuality course to alternative high school students along with a six session "Be Proud! Be Responsible!" curriculum which provides fundamental information and training regarding HIV/STD prevention.

Eastern

Planned Parenthood of Southeastern Virginia (PPSEV) conducts a series of single-session group level interventions targeting African-American women, men and youth in the rural communities of Petersburg, Surry and Hopewell. PPSEV also provides a Mobile Health Clinic in the aforementioned areas, which provides a site for health services including STD counseling and oral HIV testing.

Tidewater AIDS Crisis Taskforce (TACT) conducts "Home Health Parties," a group level intervention targeting African-American women designed to increase HIV/STD prevention knowledge, change attitudes, and reduce high-risk behavior. TACT also conducts basic and intensive street outreach targeting Injecting Drug User's (IDU's) in order to provide them with HIV/STD risk reduction information, safer sex information and injection equipment cleaning information.

MSM HIV Prevention Grants Program

Purpose: To provide innovative HIV prevention services to underserved men who have sex with men (MSM) populations throughout Virginia. This grant was established in 1998 as a result of a needs assessment and population prioritization analysis conducted by the Virginia HIV Community Planning Committee, which indicated significant gaps in services for the MSM population.

CY 2003 Funding: $130,750

Northwest

AIDS/HIV Services Group incorporates a three-fold outreach, support services, and community network approach to provide prevention to the rural MSM populations. The outreach staff frequent various venues (clubs, bookstores and communities) disseminating prevention literature. The internet outreach program utilizes a web site to provide prevention information and risk assessment surveys. Chat rooms are used to engage non-identifying MSM in conversation regarding prevention and risk reduction behaviors. The program has networked with other agencies to sponsor events to heighten community awareness about HIV/AIDS.

Southwest

Council of Community Services conducts extensive outreach services through its "Operation Life Saver" program in local clubs, parks, bookstores and other community venues to provide information on STD/HIV prevention and testing. The program maintains information booths at various social events to heighten community awareness and network with other community agencies. These activities also serve as recruitment opportunities for volunteers and participants for in-home and community prevention education programs. Quarterly newsletters are distributed to provide a media outlet for those who are isolated in rural areas and lack access to the internet and other prevention information.

Central

Minority Health Consortium conducts basic street and community outreach in local clubs frequented by MSMs of color and men on the "down low" who frequent underground social clubs, providing prevention materials and information. Outreach serves as an opportunity to enroll clients into more intensive services such as individual and group level. The transgender community level intervention (TMAC) serves as a holistic approach to HIV prevention through the efforts of outreach, counseling, mentoring, and training and education.

Fan Free Clinic, Inc. provides outreach and case management services through its "Men 4 Men" program. Basic, intensive and facilitative outreach is conducted to MSM of color. Prevention case management services are also provided for high risk MSM who are HIV positive as well as negative.

Eastern

Tidewater AIDS Crisis Task Force's Project Hope offers prevention services to gay, bi-sexual and transgender youth. Participants receive individualized support (crisis counseling and support groups) and referral services (housing, employment, education); peer mentoring, education training and outreach services; harm-reduction/life skills education through serial presentations and in-home HIV prevention emphasizing abstinence and healthy sexual decision-making. The program also sponsors various social events promoting healthy lifestyles and social development for sexual minority youth.

HIV Prevention Targeting High Risk Youth and Adults

Purpose: To expand HIV prevention education for communities and populations designated as "hard-to-reach" such as out-of-school, homeless, throwaway youth, incarcerated youth and adults. VDH through this program will continue to improve strategies to combat the HIV epidemic.

CY 2003 Funding: $350,000

Northwest

AIDS Response Effort (ARE) provides HIV prevention education to adult and youth offenders in Winchester.
AIDS/HIV Service Group (ASG) provides HIV prevention education to high-risk youth, women, homeless persons, substance abusers and their sex partners and residents of low-income housing via street outreach, peer education, and multiple session programs.

Northern

Northern Virginia AIDS Ministry (NOVAM) provides the peer education program "Youth Speak" and conducts street outreach and HIV prevention education to high-risk youth in Northern Virginia.

Southwest

Council of Community Services (CCS) provides HIV prevention education to homeless individuals in Roanoke.

Central

Fan Free Clinic provides a multi-faced program in Richmond. The first component, "Stomp 4 Life", is a hip-hop dance rhythm and rap program to educate youth about STD/HIV. The second component, "Men on the Move", is a mentor and educational program for teen fathers who attend the adult Career Development Center. The final component is street outreach targeting injecting drug users and their partner in Richmond.

Human Resources, Inc. (HRI) provides HIV/AIDS prevention education through audience participation and role-playing skits to women and high-risk youth. HRI also conducts HIV prevention education via street outreach targeting injecting drug users and their partners in Richmond.

Virginia League for Planned Parenthood (VLPP) provides HIV education to youth offenders and to youth in the Richmond community through a comprehensive human sexuality program, "Straight Talk".

Eastern

Planned Parenthood Southeastern Virginia (PPSEV) provides HIV prevention education to incarcerated youth and adults in Newport News, Hampton, and Portsmouth.

Tidewater AIDS Crisis Taskforce (TACT) provides HIV prevention education to youth in Norfolk.

African American Faith Initiative

Purpose: To provide culturally sensitive, faith-based HIV prevention programs to the African-American communities.

CY 2003 Funding: $122,967

The year 2003 marked the fifth year of the African American Faith Initiative program. Three faith institutions implemented a variety of interventions for their respective congregations and the surrounding communities. Each faith institution has been trained in and implemented the *Keeping It Real* faith-based model that provides youth with information on sex and sexuality with a biblical perspective. Two have also received training in and implemented the *Breaking the Silence* faith-based model that targets adults with information on sex and sexuality so that they may be better prepared to have open dialogue with youth about such issues.

Northwest

The Way of the Cross Community Development Center serves Albemarle, Buckingham, Fluvanna and Louisa counties. In addition to churches, Way of the Cross targets women in the Fluvanna Correctional Facility.

Central

Faith Community Baptist Church serves the east end and southside communities of Richmond.

Eastern

Basilica of St. Mary of the Immaculate Conception serves Norfolk and the surrounding area.

Primary Prevention for Persons Living with HIV

Purpose: To provide Prevention Case Management (PCM) in a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction behaviors by clients with multiple, complex problems and risk-reductions needs. PCM provides primary prevention services to HIV infected clients at highest risk for transmitting the virus. PCM is a hybrid of HIV risk reduction counseling and traditional case management that provides intensive, ongoing and individualized prevention counseling, support and service brokerage.

CY 2003 Funding: $269,000

Northern

K. I. Services, Inc. provides prevention case management services to HIV positive individuals who are considered high risk for transmitting the disease through unprotected sex and/or intravenous drug use. Populations specifically targeted are racial ethnic minorities and MSM.

Southwest

Council of Community Services provides small group prevention education, and prevention case management services in Roanoke and Martinsville. A quarterly newsletter is used as a media outlet for information concerning HIV and allows those who are isolated in rural areas, lack access to the internet or are fearful of presenting for services, primary and secondary prevention information. Recipients also had the opportunity to write and submit articles.

Central Virginia Health District provides prevention case management services to clients in Lynchburg and its surrounding counties.

Central

Virginia Commonwealth University/Medical College of Virginia Hospitals (VCU/MCVH) is funded to provide primary prevention through PCM to HIV infected persons attending the Infectious Disease Clinic who have risk behaviors, substance abuse problems, mental health issues or medication adherence difficulties. Patients are provided screening/assessments along with a client-centered care plan and provided multiple HIV counseling sessions. Services for mental health counseling and substance abuse treatment are coordinated for each client if needed.

Eastern

Urban League of Hampton Roads conducts prevention case management and support group services for HIV infected inmates and recently released ex-offenders.

The Center for Comprehensive Care of Immune Deficiency (3CID) of the Eastern Virginia Medical School is funded to provide prevention case management services to HIV infected persons attending the Infectious Disease Clinic who have high risk behaviors, substance abuse problems, mental health issues or medication adherence difficulties. A five series educational group is convened twice a year to provide information on other issues such as skills building on risk-reduction, nutrition, and exercise.

Community Collaboration Grants

Purpose: To develop effective programs for HIV prevention education in health department clinics and the communities they serve; to effectively utilize client time through interactive education; to increase collaborative efforts between local health departments and community-based organizations; and to increase client awareness of community resources.

CY 2003 Funding: $74,000

Southwest

Cumberland Plateau Health District works with the **Blue Ridge Job Corps** in Marion and the **Southwest Virginia Community College** in providing peer education programs for students.

Lenowisco Health District focuses on programs that provide health education and risk reduction information to teens and young adults. Programs target local middle and high schools, the Job Corps, and local universities and community colleges.

Central

Henrico County Health Department collaborates with the **Fan Free Clinic** to provide HIV education in the STD, Family Planning and Maternity clinics. In addition, basic, intensive and facilitative outreach services are provided to Henrico communities.

OraSure Testing and Intensive Outreach Services

Purpose: To provide oral HIV counseling and testing services targeting MSM, MSM/IDUs, IDUs and the sex partners of IDUs through street outreach activities. Special emphasis is placed on reaching people of color.

CY 2000 funding: $410,000

Northwest

AIDS Response Effort (ARE) provides counseling, OraSure testing and referral services targeting IDUs and their sexual partners in local jails and detention centers in the Winchester area.

Southwest

Council of Community Services provides counseling and OraSure testing targeting MSM, IDUs, MSM/IDUs and their sexual partners through basic and facilitative outreach in the Roanoke area. CCS also conducts community events and health fairs to reach the targeted populations.

Central

Fan Free Clinic provides intensive and community outreach, counseling and OraSure testing services targeting MSM, MSM/IDUs, IDUs and their sexual partners in the Richmond metropolitan and Petersburg areas.

Eastern

Tidewater AIDS Crisis Taskforce provides intensive outreach, facilitative outreach, counseling and OraSure testing services targeting IDUs, MSM, MSM/IDUs and the sexual partners of IDUs in Portsmouth.

MEN Inc. provides basic outreach, intensive outreach, counseling and OraSure testing targeting MSM, MSM/IDUs, IDUs and their sexual partners in Norfolk.

Hampton-Newport News Community Services Board provides basic, intensive and facilitative outreach, counseling and OraSure testing targeting MSM, MSM/IDUs and IDUs and their sexual partners.

Capacity Building Grants for Small AIDS Service Organizations

CY 2002 funding: $220,000

The purpose of the Capacity Building Grant for Small AIDS Service Organizations (ASO) was to establish contracts for small ASOS in need of assistance to enhance the capacity of the agency to provide primary HIV prevention, care and support services. Carry-over funds from 2001 were used to fund this program. Thirteen small ASOs were funded under a six-month Capacity Building Grant. This grant allowed agencies to purchase equipment and provide necessary training for staff to build a fiscally sound and responsible agencies. The agencies funded were:

Northwest	**AIDS Response Effort**
	AIDS/HIV Services Group
	Valley AIDS Network
	Way of the Cross Community Development Corporation;
Northern	**K. I. Services**
	Positive Livin'
Southwest	**Appalachian AIDS Coalition**
	Coalition for HIV Awareness and Prevention of Central Virginia
	Southside AIDS Venture
	West Piedmont AIDS Taskforce,
Central	**Crater AIDS Action Program**
	Minority Health Consortium
	The Retozon Group

Computer Grants Program

The Division of HIV/STD awarded 25 surplus computers to 15 AIDS service organizations in a first-time computer grants program. The Division had replaced a large number of its computers in late 2001; therefore, computers previously purchased with federal funds would have otherwise been sent to state surplus. A simple, two-page application process was used. While these computers did not meet the current Division's needs in terms of computing power, memory and speed, they were useful to many small CBOs that had no equipment, extremely old equipment or simply needed computers that could run standard word processing and spreadsheet programs. The computers were wiped of all information and reloaded with the Windows 95 and Microsoft Office 97 software. The CBO recipients were extremely appreciative as this gave some agencies their first computer to write reports, grants etc. and allowed other agencies to expand computer access for clients who want to conduct internet searches or other research.

Early Intervention SAPT Block Grants

Section 1924 of the Public Health Services Act directs the Department of Mental Health, Mental Retardation and Substance Abuse Services to distribute five percent (5%) of its treatment award to support the integration of HIV services with substance abuse treatment in the areas of the state that demonstrate highest level of need. The Virginia DMHMRSAS awards HIV Early Intervention Funds to 22 Community Services Boards (CSBs) to provide:

- Pre-test counseling for HIV/AIDS;
- Testing to confirm the diagnosis of AIDS, or to diagnose the extent of, and provide treatment for the disease;
- Appropriate post-test counseling;
- Providing therapeutic measures for preventing and treating the deterioration of the immune system, and conditions arising from the disease**.**

LARGER URBAN AREAS

- Alexandria
- Arlington
- Blue Ridge (Cities of Roanoke & Salem, Counties of Botetourt, Craig & Roanoke)
- Chesapeake
- District 19 (Colonial Heights, Hopewell, Petersburg, and Counties of Dinwiddie, Emporia, Greensville, Prince George, Surry and Sussex)
- Fairfax-Falls Church
- Hampton-Newport News
- Henrico County
- Norfolk
- Portsmouth
- Richmond City
- Virginia Beach

SMALLER URBAN AREAS

- Central Virginia (Cities of Lynchburg and Bedford and Counties of Amherst, Appomattox, Bedford & Campbell)
- Colonial (James City and York Counties, Poquoson and Williamsburg)
- Danville-Pittsylvania
- Valley (Cities of Harrisonburg, Staunton and Waynesboro and Rockingham, Augusta, Highland & Rockbridge Counties)
- Northwestern (Winchester and Counties of Clark, Frederick, Page, Shenandoah and Warren)
- Region Ten (Charlottesville, and Albemarle, Fluvanna, Green, Louisa, and Nelson Counties)

RURAL AREAS

- Crossroads (Counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway & Prince Edward)
- Eastern Shore (Accomack & Northampton Counties)
- Middle Peninsula (Essex, Gloucester, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond & Westmoreland Counties)
- Western Tidewater (Suffolk, Franklin, Smithfield and Counties of Southampton, Isle of Wight)

Anonymous Counseling, Testing, Referral and Partner Counseling and Referral Services

The Anonymous Counseling, Testing, Referral and Partner Counseling and Referral Services sites are funded by VDH primarily through state funds. There are 20 locations in Virginia, four sites in each health region, with some satellite locations.

Northwest

Charlottesville Health Department (ATS)
P.O. Box 7546
Charlottesville, VA 22906
Phone: (434) 972-6217
Hours: Wed. 1-4 pm, by appointment

Fredericksburg Health Department (ATS)
608 Jackson Street
Fredericksburg, VA 22401
Phone: (540) 899-4110
Hours: Mon. 9-12:30 pm, Wed. 1-4 pm, 1ST and 3rd Wed until 5:30 pm

Rockingham/Harrisonburg Health Department (ATS)
110 North Mason Street
P.O. Box 26
Harrisonburg, VA 22801
Phone: (540) 574-5220
Hours: Tues. evening

Winchester Health Department (ATS)
158 Front Royal Pike, Suite 100
Winchester, VA 22601
Phone: (540) 662-0559
Hours: Mon.-Fri. 9-1 pm for appointment

Northern

Alexandria Health Department (ATS)
517 North Saint Asaph Street
Alexandria, VA 22314
Phone: (703) 838-4389
Hours: Wed 2-3:30/Thurs 5-6:30/Fri. 9-10:30

Arlington Health Department (ATS)
1800 North Edison Street
Arlington, VA 22207
Phone: (703) 358-5200
Hours: Tues. 12-1:15 by appt. & 4-6 pm/Thurs. 1:30-2:30

Fairfax County Health Dept., Joseph Willard Health Center (ATS)
3750 Old Lee Highway
Fairfax, VA 22030
Phone: (703) 246-7100
Hours: Mon. & Wed. 8-3:30/Tues. 10-11:30/Wed. 5-6:30 pm

Prince William Health Department, Manassas Office (ATS)
9301 Lee Avenue
Manassas, VA 20110
Phone: (703) 792-6300
Hours: Tues. 1-2 pm

Southwest

Henry/Martinsville Health Department (ATS)
295 Commonwealth Blvd.
Martinsville, VA 24114
Phone: (276) 638-1804
Hours: Tues. 5–7:30 pm

Montgomery County Health Department (ATS)
210 South Pepper Street, Suite A
Christiansburg, VA 24073
Phone: (540) 381-7105
Hours: 1st & 3rd Mon. 4:30–6:30 pm

Roanoke City Health Department (ATS)
515 Eighth Street, SW
Roanoke, VA 24016
Phone: (540) 857-7600
Hours: Mon. 3–6 pm/Walk-ins

Washington County Health Department (ATS)
15068 Lee Highway, Suite 1000
Bristol, VA 24202
Phone: (276) 676-5604
Hours: Last Mon. 4:30–6 pm/Walk-ins

Wythe County Health Department (ATS)
750 West Ridge Road
Bristol, VA 24382
Phone: (276) 228-5507
Hours: 2nd Thurs./Walk-ins 4:30-7 pm

Central

Petersburg Health Department (ATS)
301 Halifax Street
P. O. Box 2081
Petersburg, VA 23804
Phone: (804) 732-7261
Hours: every other Wed 5-8 pm

Cross-Over Health Center (ATS)
108 Cowardin Avenue
Richmond, VA 23224
Phone: (804) 233-5016
Hours: Mon-Thurs. 9-4:30 pm

VA Commonwealth University Health Systems, Medical College of VA (ATS)
1200 East Broad Street
Richmond, 23298
Phone: (804) 828-2210
Hours: By appointment only

Halifax County Health Department (ATS)
P. O. Box 845
Halifax, VA 24558
Phone: (434) 476-4868
Hours: Mon. by appointment only

Eastern

Hampton Health Department (ATS)
3130 Victoria Blvd.
Hampton, VA 23661-1588
Phone: (800) 873-TEST (8378)
Hours: by appointment

Norfolk Community Health Center (ATS)
Norfolk, VA
Phone: (800) 873-TEST (8378)
Hours: by appointment

Portsmouth Health Department (ATS)
1701 High Street, Suite 102
Portsmouth, VA 23704
Phone: (800) 873-TEST (8378)
Hours: by appointment

Virginia Beach Health Department (ATS)
4452 Corporate Lane, Pembroke Corporate Center III
Virginia Beach, VA 23462
Phone: (800) 873-TEST (8378)
Hours: by appointment

Confidential Counseling, Testing, Referral and Partner Counseling and Referral Services

The Confidential Counseling, Testing, Referral and Partner Counseling and Referral Services sites are funded by VDH through the CDC Cooperative HIV Prevention Grant. There are many confidential testing sites located in each of the five health regions.

Northwest

Albemarle/Charlottesville Health Department
P.O. Box 7546
Charlottesville, VA 22906
Phone: (434) 972-6219
Hours: Tues and Friday 1-3:30 pm

Bath County Health Department
P.O. Box 120
Warm Springs, VA 24484
Phone: (540) 839-7246
Hours: by appointment, when nurse is available

Buena Vista City Health Department
2270 Magnolia Avenue
Buena Vista, VA 24416
Phone: (540) 261-2149
Hours: when nurse is available

Caroline County Health Department
P.O. Box 6
Bowling Green, VA 22427
Phone: (804) 633-5465
Hours: Mon. 8:30-3:30 pm

Clark County Health Department
100 North Buckmarsh Street
P.O. Box 327
Berryville, VA 22611
Phone: (540) 955-1033
Hours: Mon.-Fri. 8:30-11:30 am & 1-3:30 pm

Clifton Forge City Health Department
322 Jefferson Avenue
P.O. Box 15
Clifton Forge, VA 24422
Phone: (540) 862-4131
Hours: Tues. 1-3:30 by appointment

Culpeper Health Department
640 Laurel Street
Culpepper, VA 22701-3993
Phone: (540) 829-7350
Hours: Mon. 3-5 pm, Tues. 8:30-11 am & 1-3:30 pm

Fauquier County Health Department
330 Hospital Drive
Warrenton, VA 20186
Phone: (540) 347-6400
Hours: 2-3 pm walk-in (STD 1-3 pm)

Fluvanna County Health Department
County Office Bldg., Route 15
Palmyra, VA 22963
Phone: (434) 591-1960

Frederick/Winchester Health Department
150 Commercial Street
Winchester, VA 22601
Phone: (540) 722-3470
Hours: Mon.-Fri. 8:30-11:30 am & 1-3:30 pm

Fredericksburg City Health Department
608 Jackson Street
Fredericksburg, VA 22401
Phone: (540) 899-4142
Hours: Mon. 9-12:30 pm, Wed. 1-4 pm, 1st & 3rd Wed. 1-5:30 pm

Galax City Health Department
P. O. Box 926
Galax, VA 24333
Phone: (276) 236-6127
Hours: Mon. 8-11 am & 1-4 pm and by appointment

Greene County Health Department
50 Standard Street
P.O. Box 38
Standardsville, VA 22973
Phone: (434) 985-2262
Hours: Wed. 8:30-11:30 am, Thurs. 1-3 pm, walk-in immunization clinic

Highland County Health Department
Fleischer Avenue
P.O. Box 558
Monterey, VA 24465
Phone: (540) 468-2270
Hours: when nurse is available

King George County Health Department
Route 3
P.O. Box 92
King George, VA 22485
Phone: (540) 775-3111
Hours: Fri. 8-9 am

Louisa County Health Department
101 Ashley Street
P.O. Box 336
Louisa, VA 23093
Phone: (540) 967-3703
Hours: Tues. 8:30-11 am walk-ins

Madison County Health Department
400-A North Main Street
P.O. Box 67
Madison, VA 22727
Phone: (434) 948-5481
Hours: Mon. 8-10:30 am and by appointment

Nelson County Health Department
63 Courthouse Square
P.O. Box 98
Lovingston, VA 22949
Phone: (434) 263-8313
Hours: Mon. 2-4 pm

Orange County Health Department
450 North Madison Road
Orange, VA 22960
Phone: (540) 672-1291
Hours: Mon.-Fri. 8-4:30 pm

Page County Health Department
75 Court Lane
Luray, VA 22835
Phone: (540) 743-6528
Hours: Mon.-Fri. 8-11:30 am & 1-3:30 pm

Rappahannock County Health Department
491-A Main Street
Washington, VA 22747
Phone: (540) 675-3516
Hours: 8:30-10 walk-in *(changes month to month)*

Rockbridge/Lexington Health Department
300 White Street
P.O. Drawer 900
Lexington, VA 24450
Phone: (540) 463-3185
Hours: call for an appointment

Rockingham/Harrisonburg Health Department
110 North Mason Street
P.O. Box 26
Harrisonburg, VA 22801
Phone: (540) 574-5100
Hours: Mon.-Fri. 8-10am & 2-4 pm

Shenandoah County Health Department
600 North Main Street, Suite 106
Woodstock, VA 22664
Phone: (540) 459-3733
Hours: Mon.-Fri. 8:30-11:30am & 1-3:30 pm

Spotsylvania County Health Department
Route 208 – Holbert Building
Spotsylvania, VA 22553
Phone: (540) 582-7155
Hours: Fri. 8-9 am

Stafford County Health Department
P.O. Box 27
Stafford, VA 22555
Phone: (540) 659-3101
Hours: Fri. 8-12 pm

Augusta/Staunton Health Department
1414 North Augusta Street
P.O. Box 2126
Staunton, VA 24402-2126
Phone: (540) 332-7830
Hours: Mon.-Fri. 8-4:30 pm

Warren County Health Department
134 Peyton Street
Front Royal, VA 22630
Phone: (540) 635-3159
Hours: Mon.-Fri. 8:30-11:30am & 1-3:30 pm

Waynesboro City Health Department
1300 13th Street
Waynesboro, VA 22980
Phone: (540) 949-0137
Hours: usually Thurs. 1:30-3 pm *(nurse available)*

Northern

Alexandria Health Department
517 North Saint Asaph Street
Alexandria, VA 22314
Phone: (703) 838-4400
Hours: Wed. 2-3:30 & 4-6 pm, Fri. 9-10:30 am

Arlington County Health Department
1800 North Edison Street
Arlington, VA 22207
Phone: (703) 228-4992
Hours: Tues. 12-1:15 by appt. & 1-3 pm, Thurs. 3-6 pm

Fairfax County Health Department, Joseph Willard Health Center
3750 Old Lee Highway
Fairfax, VA 22030
Phone: (703) 246-7100
Hours: Mon & Wed 10-6 pm, Fri 8-12

Fairfax County Health Department
8350 Richmond Highway, Suite 233
Fairfax, VA 22306
Phone: (703) 704-5203
Hours: Mon. 2-3:30 pm, Tues. 10-6 pm, Wed. 8-3:30 pm, Fri. 10-11:30

Fairfax County Health Department, Falls Church Office
6425 Leesburg Pike
Falls Church, VA 22044
Phone: (703) 534-8343
Hours: Mon. & Wed 8-3 pm, Tues. 10-5:30 pm, Fri 7:30-11:30 am

Loudon County Health Department
102 Heritage Way, NE, Suite 101
Leesburg, VA 20176
Phone: (703) 777-0236
Hours: Mon.-Fri. 8:30-12:30 & 1-4:30 pm, Tues. 1-6 pm.

Prince William County Health Department (Manassas Office)
9301 Lee Street
Manassas, VA 20110
Phone: (703) 792-6300
Hours: Thurs. 1:30-2:30

Prince William County Health Department (Woodbridge Office)
13792 Smoketown Road
Woodbridge, VA 22192
Phone: (703) 792-7300
Hours: Tues. 1:30-2:30

Fairfax County Health Department, Herndon/Reston Office
1850 Cameron Glen Drive, Suite 100
Reston, VA 22090
Phone: (703) 481-4242
Hours: Mon. & Wed 8-3 pm, Tues. 10-5:30 pm, Fri 7:30-11:30 am

Fairfax County Health Department, Springfield Office
8136 Old Keene Mill Road
Springfield, VA 22152
Phone: (703) 569-1031
Hours: Mon. & Wed 8-3:30 pm, Tues. 10-6 pm, Fri 7:30-12

Southwest

Alleghany/Covington Health Department
321 Beech Street
Covington, VA 24426
Phone: (540) 962-2173
Hours: Mon. 8-3 pm/*other days as needed*

Amherst County Health Department
224 Second Street
Amherst, VA 24521
Phone: (434) 946-9408
Hours: Wed. 2-4 pm, Thurs. 8:30-10 am/Walk-ins

Appomattox County Health Department
401 Court Street
Appomattox, VA 24521
Phone: (434) 352-2313
Hours: Mon., Thurs., 8:30, Wed. 2-4 pm

Bedford County Health Department
603 Mountain Avenue
P.O. Box 148
Bedford, VA 24523
Phone: (540) 586-7952
Hours: 1st & 3rd Fri. Walk-ins 2-4 pm

Bland County Health Department
Jackson Street
P. O. Box 176
Bland, VA 24315
Phone: (276) 688-3642
Hours: By appointment only

Botetourt County Health Department
21 Academy Street
Fincastle, VA 24090
Phone: (540) 473-8240
Hours: Wed. 8:15-11 am & 1-3 pm

Bristol City Health Department
205 Piedmont Avenue
Bristol, VA 24201
Phone: (276) 642-7345
Hours: Fri. by appointment

Buchanan County Health Department
Route 83 Slate Creek Road
P. O. Box 618
Grundy, VA 24614
Phone: (276) 935-4591
Hours: M-F 8-4:30 pm

Campbell County Health Department
116 Kabler Avenue
P. O. Box 160
Rustburg, VA 24588
Phone: (434) 332-9550
Hours: Fri. 9-10:30 am

Carroll County Health Department
605-15 Pine Street
Hillsville, VA 23434
Phone: (276) 728-2166
Hours: Mon. & Wed. 8-4:30 pm

Craig County Health Department
Main Street
P.O. Box 6
New Castle, VA 24127
Phone: (540) 864-5136
Hours: By appointment only

Danville City Health Department
326 Taylor Drive
Danville, VA 24541
Phone: (434) 799-5190
Hours: Mon. 8:15-10 am

Dickenson County Health Department
Brush Creek Road
P.O. Box 768
Clintonwood, VA 24228
Phone: (276) 926-4979
Hours: Fri. 8-4 pm

Floyd County Health Department
815 East Main Street, Rt. 221, South
Floyd, VA 24091
Phone: (540) 745-2141
Hours: Tues. 1-3 pm

Franklin County Health Department
365 Pell Avenue
P.O. Box 249
Rocky Mount, VA 24151
Phone: (540) 484-0292
Hours: Tues. 9-10 am

Giles County Health Department
120 North Main Street
Pearisburg, VA 24134
Phone: (540) 921-2891
Hours: Tues. 8-10 am

Grayson County Health Department
186 West Main
P. O. Box 650
Independence, VA 24348
Phone: (276) 773-2961
Hours: Mon. 8-4:30 pm, Tues. walk-ins 8-4:30 pm

Lee County Health Department
Hill Street
P.O. Box 763
Jonesville, VA 24263
Phone: (276) 346-2011
Hours: Mon.-Fri. 8-4:30 pm walk-ins

Lynchburg City Health Department
1900 Thomson Drive
P. O. Box 6056
Lynchburg, VA 24505
Phone: (434) 947-6777
Hours: Mon.-Fri. 2-4 pm

Mount Rogers Health District
201 Francis Marion Lane
Marion, VA 24354-4227
Phone: (276) 781-7450

Henry/Martinsville Health Department
295 Commonwealth Blvd.
Martinsville, VA 24114
Phone: (276) 638-2311
Hours: Tues. 5-7:30 pm

Montgomery County Health Department
210 South Pepper Street, Suite A
Christiansburg, VA 24073
Phone: (540) 381-7105
Hours: Fri. 8-10:30 am

Patrick County Health Department
106 Rucker Street, Suite 123
P. O. Box 428
Stuart, VA 24171
Phone: (276) 694-3188
Hours: by appointment

Pittsylvania County Health Department
200 H. G. McGee Drive
P. O. Box 1159
Chatham, VA 24531
Phone: (434) 432-7232
Hours: Thurs. 1-3:00 pm

Pulaski County Health Department
170 Fourth Street, NW
Pulaski, VA 24301
Phone: (540) 994-5030
Hours: Wed. 8-10:00 am walk-ins

Radford City Health Department
212 Third Avenue
Radford, VA 24141
Phone: (540) 831-5774
Hours: Mon. 8-10:00 am

Roanoke City Health Department
515 Eighth Street, Southwest
Roanoke, VA 24016
Phone: (540) 857-7600
Hours: Mon. 3-6:00 pm walk-in

Roanoke County/Salem Health Department
105 East Calhoun Street
Salem, VA 24153-1144
Phone: (540) 387-5530
Hours: by appointment Mon.-Fri.

Roanoke County/Vinton Health Department
227 South Pollard Street
Vinton, VA 24179
Phone: (540) 857-7800
Hours: by appointment

Russell County Health Department
155 Rogers Street
Lebanon, VA 24266
Phone: (276) 889-7621
Hours: Mon., Wed., Thurs., Fri. 1-3:30 pm, Tues. 8-11:30 am

Scott County Health Department
112 Beech Street, Suite 1
Gate City, VA 24251
Phone: (276) 386-1312
Hours: Mon.-Fri. 8-4:45 pm walk-ins

Smyth County Health Department
201 Francis Marion Lane
Marion, VA 24354-4227
Phone: (276) 781-7460
Hours: Thurs. by appointment

Tazewell County Health Department
Ben Bolt Avenue
P. O. Box 350
Tazewell, VA 24651
Phone: (276) 988-5585
Hours: Tues. & Thurs. 8-4:30 pm walk-ins

Washington County Health Department
15068 Lee Highway, Suite 1000
Bristol, VA 24202
Phone: (276) 676-5604
Hours: Tues. & Thurs. by appointment

Wise/Norton Health Department
134 Roberts Street, Southwest
Wise, VA 24293
Phone: (276) 328-8000
Hours: Mon.-Fri. 8-4:00 pm walk-ins

Wythe County Health Department
750 West Ridge Road
Bristol, VA 24202
Phone: (276) 228-5507
Hours: Mon.-Fri. 8-4:30 pm

<u>Central</u>

Amelia County Health Department
1623 Church Street
Amelia, VA 23002
Phone: (804) 561-2711
Hours: Wed. 8-11 am

Brunswick County Health Department
1632 Lawrenceville Plank Road
Lawrenceville, VA 23868
Phone: (434) 848-2525
Hours: Wed. 1-4 pm *when nurse is available*

Buckingham County Health Department
P. O. Box 198
Highway 60
Buckingham, VA 23921
Phone: (434) 969-4244
Hours: Wed. 1-3:30 pm

Charles City County Health Department
7501 Adkins Road
Charles City, VA 23030
Phone: (804) 829-2490
Hours: Mon. 8:30-11 am & 1-3:30 pm

Charlotte County Health Department
Highway 40 West
P. O. Box 670
Charlotte Courthouse, VA 23923
Phone: (434) 542-5251
Hours: Mon. 8:30-11 am

Chesterfield County Health Department
9501 Lucy Corr Circle
P. O. Box 100
Chesterfield, VA 23834
Phone: (804) 748-1743
Hours: Mon. 3-4 pm, Thurs. 1-3 pm

Colonial Heights Health Department
200 Highland Avenue
P. O. Box 3401
Colonial Heights, VA 23834
Phone: (804) 520-9380
Hours: Tues. 8:30-11 am & 1-4 pm

Cumberland County Health Department
15 Foster Road
P. O. Box 107
Cumberland, VA 23040
Phone: (804) 492-4661
Hours: Wed. 8:30-11am

Dinwiddie County Health Department
14006 Boydton Plank Road
P. O. Box 185
Dinwiddie, VA 23841
Phone: (804) 469-3771
Hours: Mon. 8:30-11am & 1-4 pm, Thurs. by appointment

Piedmont Health District
111 South Street, First Floor
Farmville, VA 23901
Phone: (434) 392-3984
Hours: Tues. 9-11 am

Goochland County Health Department
2938 River Road
P.O. Box 178
Goochland, VA 23063
Phone: (804) 556-5343
Hours: Mon.-Fri. call first for nurse availability

Greensville/Emporia Health Department
101 Spring Street
P. O. Box 1033
Emporia, VA 23847
Phone: (434) 348-4210
Hours: Mon. 1-4 pm, Wed. 8:15-4:30 pm

Halifax County Health Department
P.O. Box 845
Halifax, VA 24558
Phone: (434) 476-4863
Hours: Fri. 8:30-11 am & 3:30-6 pm

Hanover County Health Department
12312 Washington Highway
Ashland, VA 23005
Phone: (804) 365-4313
Hours: Thurs. 12:45-1:45 pm

Henrico County Health Department (West)
Henrico Government Center, Human Services Bldg.
8600 Dixon Powers Drive
Richmond, VA 23228
Phone: (804) 501-4651
Hours: Tues. *(family planning)*

Henrico County Health Department (East)
Glen Echo Office Building
3810 East Nine Mile Road
Richmond, VA 23223
Phone: (804) 652-3190
Hours: Tues. 8:30-12, Mon. 8-11 am *(family planning)*

Hopewell City Health Department
220 Appomattox Street
Hopewell, VA 23860
Phone: (804) 458-1297
Hours: 1st & 3rd Tues. 3-4 pm

Lunenburg County Health Department
11387 Courthouse Road, Highway 40/49
Lunenburg, VA 23952
Phone: (434) 696-2346
Hours: Tues. 8-11 am & 1-3 pm

Mecklenburg County Health Department
478 Washington Street
P. O. Box 370
Boydton, VA 23917
Phone: (804) 738-6333
Hours: 1st Mon. 1-4 pm *(if nurse available)*

New Kent County Health Department
12007 Courthouse Circle
P. O. Box 86
New Kent, VA 23124
Phone: (804) 966-9640
Hours: Thurs. 8:30-11 & 1-3:30 pm

Nottoway County Health Department
P.O. Box 27, Road #625
Nottoway, VA 23955
Phone: (434) 645-7595
Hours: Mon. 8:30-11 am

Petersburg City Health Department
301 Halifax Street
Petersburg, VA 23804
Phone: (804) 863-1652
Hours: Mon/Wed/Fri. 8:15-10 am

Powhatan County Health Department
3908 Old Buckingham Road
P. O. Box 12
Powhatan, VA 23139
Phone: (804) 598-5680
Hours: by appointment only

Prince Edward County Health Department
111 South Street, Ground Floor
Farmville, VA 23901
Phone: (434) 392-8187
Hours: Tues. 9-11 am

Prince George County Health Department
6450 Administration Drive
P. O. Box 69
Prince George, VA 23875
Phone: (804) 733-2630
Hours: by appointment only

Richmond City Health Department
500 North 10th Street, Room 114
Richmond, VA 23219
Phone: (804) 646-6855
Hours: Mon/Wed/Fri. 7:30-10:30 am

Surry County Health Department
474 Colonial Trail West
P.O. Box 213
Surry, VA 23883
Phone: (757) 294-3185
Hours: Thurs. 8:30-3 pm *(family planning)* & by appointment

Sussex County/Salem Health Department
20103 Princeton Road
P. O. Box 213
Sussex, VA 23884
Phone: (804) 246-8611
Hours: Mon. 1-4 pm walk-ins & by appointment.

Eastern

Accomack County Health Department
23191 Front Street
P. O. Box 177
Accomack, VA 23301-0177
Phone: (757) 787-5880
Hours: everyday walk-ins

Chesapeake Health Department
748 Battlefield Blvd. North
Chesapeake, VA 23320
Phone: (757) 382-8600
Hours: Mon.-Fri. 8:30-11:30 & 1-3:30 pm

Essex County Health Department
423 North Church Lane
P. O. Box 206
Tappahannock, VA 22560
Phone: (804) 443-3396
Hours: 8:30- 4:30 pm (changes with Nurse availability)

Franklin City Health Department
200 Fairview Drive
P. O. Box 595
Franklin, VA 23851
Phone: (757) 562-6109
Hours: Mon-Fri. 8- 11 am and 1-3 pm

Gloucester County Health Department
7384 Carriage Court
P. O. Box 663
Gloucester, VA 23061
Phone: (804) 693-2445
Hours: Mon. 8-12 and by appointment

Hampton City Health Department
3130 Victoria Blvd.
Hampton, VA 23661-1588
Phone: (757) 727-1172
Hours: Mon-Fri. 8-11 & 1-3 pm

Isle of Wight County Health Department
402 Grace Street
P. O. Box 309
Smithfield, VA 24301
Phone: (757) 357-4177
Hours: 9-11am daily *(except Tues)*

King & Queen County Health Department
Allen Circle
P. O. Box 8
King & Queen Court House, VA 23085
Phone: (804) 785-6154
Hours: Wed. by appointment and 1st and 3rd Tuesday

King William County Health Department
172 Courthouse Lane
P. O. Box 155
King William, VA 23086
Phone: (804) 769-3079
Hours: Wed. by appointment

Lancaster Health Department
9049 Mary Ball Road
P. O. Box 158
Lancaster, VA 22503
Phone: (804) 462-5197
Hours: Tues. 8-11 am (Please call ahead)

Mathews County Health Department
Courthouse Road
P.O. Box 26
Mathews, VA 23109
Phone: (804) 725-7131
Hours: 1st Wed. & 3rd Thurs. 8-4:30 pm & Friday 8:30-11 am

Middlesex County Health Department
2780 Puller Highway
P. O. Box 415
Saluda, VA 23149
Phone: (804) 758-2381
Hours: 1st & 3rd Mon. 8-11 & 1-3:30 pm

Newport News City Health Department (Peninsula Health District)
416 J. Clyde Morris Blvd.
Newport News, VA 23601
Phone: (757) 594-7300
Hours: Mon.-Fri. 8:30-11 & 1-4 pm

Norfolk City Health Department
830 Southampton Ave., Suite 200
Norfolk, VA 23510
Phone: (757) 683-2796
Hours: Mon-Fri. 1-3:30 pm

Northampton County Health Department
7114 Lankford Highway
P. O. Box 248
Nassawadox, VA 23413-0248
Phone: (757) 442-6228
Hours: Mon-Fri. 8-11:30 & 1-4

Northumberland County Health Department
6373 Northumberland Highway, Suite B
P. O. Box 69
Heathsville, VA 22473
Phone: (804) 580-3731
Hours: Tues. 1-3 pm

Portsmouth City Health Department
1701 High Street, Suite 102
Portsmouth, VA 23704
Phone: (757) 393-8585
Hours: Mon-Fri. 8-4:30 pm

Richmond County Health Department
102 West Richmond Road
P. O. Box 700
Warsaw, VA 22572
Phone: (804) 333-4043
Hours: Wed. 8:30-11 am

Southampton County Health Department
26022 Administration Center Drive
P. O. Box 9
Courtland, VA 23837
Phone: (757) 653-3040
Hours: Mon-Fri. 9-11 & 1-3 pm walk-ins

Suffolk County Health Department
1217 North Main Street
P. O. Box 1587
Suffolk, VA 23439-1587
Phone: (757) 686-4900
Hours: Mon-Fri. 8-4 pm

Virginia Beach City Health Department
4452 Corporate Lane, Pembroke Corporate Center III
Virginia Beach, VA 23462
Phone: (757) 518-2700
Hours: Mon., Tues., Thurs., 8:15 & 12:30 walk-ins

Westmoreland County Health Department
18849 King's Highway (A.T. Johnson Human Service Bldg.)
Montross, VA 22520
Phone: (804) 493-1124
Hours: 1st and 3rd Wednesdays & some Mondays

V. Gap Analysis

Assessment of Met and Unmet HIV Prevention Needs in Virginia

The HCPC was dissatisfied with the gap analysis process used for the 2000 Plan and tried to develop a more quantitative method. The Co-Chairs and members attended gap analysis sessions at the Community Planning Leadership Summit in 2002 and requested technical assistance from national providers but did not identify any models that were deemed workable for Virginia.

Using 2001 statewide evaluation data, the number of persons reached by intensive interventions (PCM, individual level, group level and intensive street outreach) was generated by target population. The number of people reached through basic outreach, presentations, mass media and testing was not included.

Next, the size of each target population living in Virginia was estimated. Finally, the HCPC attempted to quantify the percentage of each target population that was at risk for HIV based on state and national risk behavior surveys and other information. For some populations, such as MSM, recent Virginia-specific risk data existed. For broad population categories such as heterosexual adults or racial/ethnic minorities, there was little information on which to calculate the percentage of the populations that were engaging in risk behaviors.

The end result showed that at best, 50% of some population needs were being met. Because the unmet need in each population category was so great, further use of this approach to define unmet needs was abandoned. This calculation may be more useful in a more limited geographic area such as a city or neighborhood.

In the previous Comprehensive Plan, unmet needs were defined as resources, political and social factors, community action and programs needed to ensure sufficient and effective services for the population rather than a numerical assessment of the number of people in need of services. As technical assistance had not identified an improved process, the HCPC returned to its previous assessment method.

The HIV Community Planning Committee was asked to assess the current status of the priority unmet needs identified in 1999 for the 2000 HIV Prevention Comprehensive Plan. Since that time, there have been new grant programs developed and shifts in funding. Each member was provided with the list of needs by population and asked to assess whether those needs were now "Met", "Partially Met", or "Not Met".

To determine these ratings, members used

- information about HIV/AIDS prevalence and incidence in Virginia contained in the Epidemiologic Profile and Quarterly HIV Surveillance Report;
- information about currently funded populations from the Resource Inventory;
- maps of Virginia detailing locations of Health Education/Risk Reduction interventions provided for each population;

- maps of Virginia detailing locations of Anonymous, Confidential, and Oral HIV testing sites;
- comparisons of the number of people at risk and being reached with interventions; and
- member expertise.

It also should be noted that the populations for prioritization were reevaluated in the 2001 Update to the 2000 Comprehensive Plan. Members were also asked to include unmet needs for populations not previously evaluated. Below is the list of unmet needs and a summary of the Group's process.

Priority Unmet Needs from the 2000 Comprehensive Plan

Persons with HIV

1. Prevention Case Management.
2. Develop prevention programs and messages about co-infection.
3. Get African-American men (gay and straight) into services.
4. Primary Prevention Services for persons who intentionally or unintentionally infect others.
5. Secondary prevention.

Discussion: Overall, the majority of committee members (63%) felt that the needs of Persons with HIV/AIDS were **partially met**. Individuals indicated that there are many services available, although Prevention Case Management seemed to be limited in some areas. The only need **not met** is primary prevention services for persons who intentionally or unintentionally infect others.

Racial/Ethnic Minorities

1. Services to illegal immigrants and migrant communities including bilingual education.
2. Programs for Asian/Pacific Islanders including bilingual education.
3. Address misconceptions about transmission and the drug/alcohol connection to sex among Latinos/Hispanics.
4. Provide more visible messages through use of the media—especially TV.
5. Basic prevention among persons of lower socioeconomic status and education level.
6. Black community leadership and presence about HIV.

Discussion: Overall, the majority of committee members (63%) felt that the needs of Racial Ethnic Minority groups are **not met**. Although there are services available throughout Virginia, the services are limited. In some areas, these needs are not addressed. For the need of "basic prevention among persons of lower socioeconomic status and education level", 63% of the Committee saw this as a **partially met** need. Reasoning was that although there are plenty of services for low socioeconomic status, the *definition* of socioeconomic status needs to be addressed. Many members felt that low-income housing does not necessarily mean a low-income status. The observation

was that there were agencies targeting housing projects as a means to identify persons with lower incomes and education levels, the members did not feel this method was appropriate.

Injecting Drug Users

1. Creation of a needle/syringe exchange program.
2. Change in pharmacy laws/procedures to improve access to needles.
3. Develop prevention programs and messages about co-infection with TB, hepatitis A, B and C.
4. Pharmacist education.
5. Harm reduction programs.

Discussion: Needs for Injecting Drug Users are not being met according to 93% of the Committee. The Committee did acknowledge that needs like needle exchange programs and changes in pharmacy laws to allow access to needles were legislative issues that could not be directly addressed through health education and risk reduction activities. In addition, the Committee wanted to address the needs of Transgender persons who inject hormones.

Men Who Have Sex with Men

1. Cultural diversity specific to behaviors and values among all MSM programs especially for youth.
2. Culturally appropriate programs for African-American men.
3. Intensive prevention education for MSM identified as high risk.
4. Creation of peer support and safe environments for African-American men.
5. Establishment of referral mechanisms for medical and behavioral health services for high-risk MSM.

Discussion: The needs of Men who Have Sex with Men are **partially met** according to 63% of the Committee. The consensus is that prevention education has been addressed fairly well for adult MSM; however, it has not been addressed well for youth MSM. The Committee would like to see more and better services available for youth MSM.

Heterosexuals (Note: This category was identified as *Women* in the 2000 Comprehensive Plan.)

1. Safer sex education for newly arrived Hispanic immigrant women.
2. Encourage counseling about prenatal testing.
3. Provision of HIV prevention interventions to men.
4. Provision of culturally sensitive and diverse safer sex/skills training.
5. Provision of transportation.

Discussion: Overall, prevention interventions for heterosexuals are lacking. Each need listed above was indicated by 63% of the Committee as **not met.** The Committee addressed safety concerns for Hispanic immigrant women who may have entered the United States illegally. This population may have a great need for services, but because of fear of deportation they may not access available services.

Inmates

1. Access to condoms and dental dams.
2. Develop prevention programs and messages about related infections including TB, Hepatitis B and C.
3. Discharge planning for HIV+ persons.
4. Basic HIV prevention education.
5. Skills building in pre-release programs.

Discussion: The needs of Inmates are **partially met** (63% of the Committee) on the issues of basic HIV prevention education, discharge planning, and developing prevention programs and messages. The Committee stressed that the key to meeting these needs are through access to condoms and dental dams, which is currently an **unmet** need. The Committee was divided on whether skills building in pre-release programs were **unmet** or **partially** met. The consensus was that programming for those about to leave prison, which addresses both HIV positive and negative aspects, was essential. However, since access to inmates and content of presentations is controlled by the Department of Corrections, significant barriers to this population remain.

Youth

1. Programs for gang members and delinquent youth.
2. Parent education.
3. Support and role models for gay youth.
4. Data on teen behaviors-Youth Risk Behavior Survey Implementation.
5. Realistic school based education that combines abstinence and safer sex messages.

Discussion: Overall, 63% of the Committee thought that the needs of Youth in Virginia are **not met**. The Committee did not know of any existing programs targeting gang members. The current school-based sex education program is an abstinence only program that does not use safer sex messages. The only need that received a **partially met** status was support and role models for gay youth. This is because of several community-based organizations like SMYAL (DC) and ROSMY (Richmond) which provide services for GLBT youth. However, there is still a lack of attention focused on gay female youth.

Populations of Special Interest (not prioritized)

- Transgender persons

- Homeless
- Persons who sell or trade sex
- Mentally Ill/Mentally Retarded

The Committee did not rank unmet needs for these populations in 1999.

Across Populations

1. Street Outreach that is more comprehensive and intensive.
2. Sustained contact with clients (six or more sessions).
3. HIV training/education for clergy.
4. Access to OraSure testing.
5. Peer education for all populations.

Discussion: Street Outreach is **partially met** due to the structuring of street outreach standards and yearly street outreach trainings. Sustained contact with clients was split between **partially met** and **unmet**. Reasons for this included the nature of the clients receiving street outreach (i.e. drug use and homelessness among clients), street outreach skills of the outreach workers and weather issues. HIV training for clergy is **not met**. Sufficient clergy representation is still needed. Access to OraSure testing is **partially met**. Agencies in the larger cities of Virginia have the infrastructure to ensure that the community has access to alternative testing methods. Agencies in rural areas do not have enough staff or opportunity to provide access to OraSure. Peer education for all populations is a **partially met** need.

Identifying & Prioritizing Unmet Needs

The method used to identify and prioritize unmet needs for the 2003 Plan was based on the Priority Setting Worksheet Number 1: Prevention Needs provided by The Academy of Education Development (AED). There are eight factors used to consider in setting priorities:

1. Size of the at-risk population
2. HIV seroprevalence
3. Riskiness of population behaviors
4. Prevalence of risky behaviors in the population
5. Difficulty of meeting need
6. Multiple high risk populations
7. Emerging issues
8. Resources already targeting the population

For the 2000 HIV Prevention Comprehensive Plan, an ad hoc committee determined that factors 1 – 4 were incorporated into the population prioritization process, which included HIV

and AIDS morbidity, riskiness data and the size of the population. Therefore, those factors were already applied in the ranking process of the priority populations.

The remaining four factors (5-8) were used to determine unmet needs for each priority population. Each factor was equally weighed, and the group expanded the definitions for improved understanding for the full Committee.

The following definitions were approved by the HCPC. The sentences in bold were provided as instructions for evaluating each need.

Definitions of the four factors:

1. Difficulty of Meeting the Need

Implementing programs to meet the identified need will range from relatively easy to very difficult, based on such factors as identifying/reaching target populations, complexity of need, capacity/ability of service providers, accessibility, acceptability, etc. **Assess the difficulty of addressing the identified need.**

2. Multiple High-Risk Populations

Within the target population, several at-risk populations may exist, defined by either demographics or behaviors. **Assess the extent to which the identified need addresses these sub-populations or multiple risk behaviors among the population.**

3. Emerging Issues

The population is affected by relatively new or emerging factors in the transmission of HIV within the particular community. (STD incidence, impact of new medications on risky behaviors, safer sex relapse, and illicit drug use patterns, etc.) **Assess the extent to which the identified need addresses an emerging issue for the target populations.**

4. Lack of Existing Resources

The extent to which the population currently experiences a range of resources (programs, funding, interventions) aimed at reducing the spread of HIV in the community. **Assess the extent to which the identified need is NOT currently being met. Low score if need is being met, high score if need is largely unmet.**

These factors were reviewed in 2002 for the current needs assessment process. The Committee voted to use the same factors. The strategies used to generate the list of identified needs were:

- An HIV prevention and care organizational needs assessment completed by ASOs and other service providers across Virginia
- Town meetings held in each of the five health regions during 2001
- Results from population specific surveys conducted for the HCPC
- Previous unmet needs and

- The Epidemiologic Profile

In November 2002, members were provided the definitions and instructions to rank each of the identified needs by the four factors on a scale of 1 – 5. Members were asked to rank the needs of each population, particularly the populations that they represented and/or identified as their areas of expertise.

Before completing the task, each population was reviewed and the sub-populations for each prioritized population were identified. The **Multiple High-Risk Populations** category was meant to look at the subpopulations developed for each prioritized population. However, the Committee decided that the **Multiple High-Risk Populations** category would be excluded in ranking the needs for populations of special interest (non-prioritized), since those populations could also be represented in the prioritized populations. In addition to the eleven target populations (7 prioritized and 4 populations of special interest), categories for needs "across populations" and "agency" needs were used to address provider issues or needs that did not fit within the defined populations. The needs (in no particular order) by population priority ranked by the Committee were:

Unranked Needs of Prioritized Populations

Persons with HIV/AIDS

- Prevention education for PWHA including information on Human Sexuality, address myths (e.g. medication preventing transmission), and educational materials specifically on living with HIV.
- Linkages to assessment and treatment for persons with dual diagnoses (substance abuse, mental health, etc.)
- Empowerment of consumers to achieve self-efficacy to optimize quality of life and health.
- Prevention Case Management.
- Develop prevention programs and messages about co-infection.
- Get African-American men (gay and straight) into services.
- Primary prevention services for persons who intentionally or unintentionally infect others.
- Secondary prevention.

Racial/Ethnic Minorities

- Basic HIV 101 education to minorities, including topics on blood donation myths, lambskin condoms, and information about types of condoms available.
- Bilingual educational materials.

- Formal clergy training and more involvement from minority churches.
- Faith based/religious educational material.
- Linkages between Black churches, ASOs, and health departments.
- Outreach programs for immigrants, including undocumented immigrants.
- Services to migrant communities.
- One-on-one counseling for Hispanics and Asians.
- Outreach programs for American Indians.
- Programs for Asian/Pacific Islanders, including bilingual education.
- Address misconceptions about transmission and the drug/alcohol connection to sex among Latinos/Hispanics.
- Provide more visible messages through use of the media, especially TV.
- Basic prevention among persons of lower socioeconomic status and education level.
- Black Community leadership and presence about HIV.

IDU

- Peer Education programs.
- Increase access to clean needles and syringes.
- Pharmacist education.
- Harm reduction programs.
- Education regarding viral hepatitis (A, B and C).
- Peer advocacy.
- Additional substance abuse treatment slots, including detox.
- Creation of a needle/syringe exchange program.
- Change in pharmacy laws/procedures to improve access to needles.

MSM

- Linkages to alcohol and substance abuse counseling.
- Effective/scientifically supported interventions for MSM of color.
- Outreach programs.

- Comprehensive health education for men that includes STDs, viral hepatitis, domestic violence, self-exams, etc.
- Faith-based education/linkages for MSM of color.
- Cultural diversity specific to behaviors and values among all MSM programs, especially for youth.
- Culturally appropriate programs for African American men.
- Intensive prevention education for MSM identified as high risk.
- Creation of peer support and safe environments for African-American men.
- Establishment of referral mechanisms for medical and behavioral health services for high-risk MSM.

Heterosexuals

- Partner neutral education for men.
- HIV education for people with disabilities such as deafness or blindness.
- Provision of childcare.
- HIV/STD intensive interventions in rural areas.
- Involvement of faith-based communities.
- Outreach and education for heterosexual men.
- Education regarding domestic violence.
- Education targeting women who are having sex with both men and women.
- Safer sex education for newly arrived Hispanic immigrant women.
- Encourage counseling about prenatal testing.
- Provision of culturally sensitive and diverse safer sex/skills training.
- Provision of transportation.

Inmates

- Aftercare and counseling for youth offenders.
- Training of staff in prison/jail settings on all aspects of HIV knowledge and care.
- Free HIV testing on demand.

- Improve linkages through probation and parole systems.
- Access to condoms and dental dams.
- Pre-release HIV/STD education.
- Pre-release education on accessing medications and services.
- Develop prevention programs and messages about related infections including TB, Hepatitis B and C.
- Discharge planning for HIV positive persons.
- Skills building in pre-release programs.
- Basic HIV prevention education.

Youth

- Education on how to access to HIV and STD testing.
- Education on how to access condoms.
- Blend HIV education into other topic areas.
- Skills building and negotiation activities with reinforcement for healthy behaviors and choices. Instill a sense of responsibility and ownership of choices made.
- Peer education modules that include adult mentors.
- Improved comprehensive sex education in schools, especially for younger grades using an approach that combines abstinence and safer sex messages.
- Parent education and communication skills training through linkages with PTAs and PTOs.
- Transportation to programs.
- Drop-in centers.
- Programs for gang members and delinquent youth.
- Support and role models for gay youth.
- Data on teen behaviors -Youth Risk Behavior Survey Implementation.
- Realistic school-based education that combines abstinence and safer sex messages.

Transgendered Persons

- Specific HIV programs/interventions that respond to needs of transgendered persons.

- Peer advocacy and education.
- Education and harm reduction regarding risks of needle sharing.
- Provision of counseling and support regarding self-esteem and other mental health issues.
- Outreach to address the needs of sex workers.
- Improved linkages and access to care.

Homeless

- Need for safe places (shelters, half way houses).
- Comprehensive education on HIV, STDs, TB and viral hepatitis.
- Basic outreach with referral to an array of services (testing, health care, substance abuse treatment, mental heath services, housing, etc.)
- Transportation to services.
- Appropriate referrals for individuals with dual or triple diagnoses.

Persons who sell or trade sex

- Need for safe places (shelters).
- Job training.
- Education regarding domestic violence.
- Education on substance abuse and viral hepatitis.
- Referrals and assistance in accessing substance abuse treatment.
- Peer advocacy and education.
- Harm reduction programs.

Mentally Ill/Mentally Retarded

- Basic educational programs for mentally ill/mentally retarded populations.
- Training for MI/MH service providers on HIV and other sexually transmitted infections.

Across Populations

- Focus groups to obtain more information from target populations.
- Stronger linkages between prevention programs and testing.

- Increased media support: web pages, billboards, buses, etc.
- Support groups.
- Street Outreach that is more comprehensive and intensive.
- Sustained contact with clients (six or more sessions).
- HIV training/education for clergy.
- Access to OraSure testing.
- Peer education for all populations.

Agencies

- Capacity building for agencies.
- Additional technical assistance.
- Collaboration among agencies to conduct prevention campaigns together.
- Resource guide for prevention services.
- Cultural Competency training for service providers.
- Spanish language training for service providers.
- Training for providers on how best to access and serve racial/ethnic minority populations.
- Identify and engage additional minority prevention and health care service providers.
- Cross training between Substance Abuse counselors and AIDS service organization staff.
- Training for educators/providers in non-judgmental communication, homophobia and cultural diversity of MSM lifestyles.
- Preparation of educators to provide age-appropriate response to HIV/STD and human sexuality questions from youth.
- Sensitivity training and education for providers on transgender populations and issues.
- Education to clergy regarding needs of homeless populations.
- Strengthen the science base of interventions.
- Implement standards for HIV education.

Results

Scores were totaled and averaged. The HCPC reviewed the results to determine which needs were met and what gaps remained. The following is the resulting gap in services for each of the prioritized populations including special populations, agency needs and needs across all populations. Each unmet need has been ranked from largest remaining need to smallest remaining need.

Persons with HIV/AIDS

1. Get African-American men (gay and straight) into services.
2. Prevention Case Management.
3. Linkages to assessment and treatment for persons with dual diagnoses (substance abuse, mental health, etc.)
4. Prevention education for PWHA including information on Human Sexuality, address myths (e.g. medication preventing transmission), and educational materials specifically on living with HIV.
5. Primary Prevention Services for persons who intentionally or unintentionally infect others.

Racial/Ethnic Minorities

1. Services to migrant communities.
2. Outreach programs for immigrants including undocumented immigrants.
3. One-on-one counseling for Hispanics and Asians.
4. Provide more visible messages through use of the media, especially TV.
5. Basic prevention among persons of lower socioeconomic status and education level.

IDU

1. Increase access to clean needles and syringes.
2. Additional substance abuse treatment slots, including Detox.
3. Creation of a needle/syringe exchange program.
4. Change in pharmacy laws/procedures to improve access to needles.
5. Harm reduction programs.
6. Peer Education programs.

MSM

1. Intensive prevention education for MSM identified as high risk.
2. Effective scientifically-supported interventions for MSM of color.
3. Faith-based education/linkages for MSM of color.
4. Creation of peer support and safe environments for African-American men.
5. Incorporation of cultural diversity specific to behaviors and values among all MSM programs, especially for youth.

Heterosexuals

1. HIV/STD intensive interventions in rural areas.
2. Safer sex education for newly arrived Hispanic immigrant women.

3. Education targeting women who are having sex with both men and women.
4. Partner neutral education for men.
5. HIV educational for people with disabilities such as deafness or blindness.

Inmates

1. Free HIV testing on demand.
2. Access to condoms and dental dams.
3. Skills building in pre-release programs.
4. Training of staff in prison/jail settings on all aspects of HIV knowledge and care.
5. Discharge planning for HIV-positive persons.
6. Pre-release HIV/STD education.

Youth

1. Support and role models for Gay, Lesbian, Bisexual, Transgender, and Intersex (GLBTI) youth.
2. Realistic sex education in schools, especially for younger grades, using an approach that combines abstinence and safer sex messages.
3. Programs for gang members and delinquent youth.
4. Drop-in centers.
5. Skills building and negotiation activities with reinforcement for healthy behaviors and choices. Instill a sense of responsibility and ownership of choices made.
6. Data on teen behaviors -Youth Risk Behavior Survey Implementation.

Transgendered Persons

1. Specific HIV programs/interventions that respond to needs of transgendered persons.
2. Outreach to address the needs of sex workers.
3. Peer advocacy and education.
4. Provision of counseling and support regarding self-esteem and other mental health issues.
5. Improved linkages and access to care.
6. Education and harm reduction regarding risks of needle sharing.

Homeless

1. Appropriate referrals for individuals with dual or triple diagnoses.
2. Transportation to services.
3. Need for safe places (shelters, half way houses).
4. Comprehensive education on HIV, STDs, TB and viral hepatitis.
5. Basic outreach with referral to an array of services (testing, health care, substance abuse treatment, mental heath services, housing etc.)

Persons who sell or trade sex

1. Need for safe places (shelters).
2. Harm reduction programs.
3. Job training.
4. Peer advocacy and education.
5. Referrals and assistance in accessing substance abuse treatment.

Mentally Ill/Mentally Retarded

1. Basic educational programs for mentally ill/mentally retarded populations.
2. Training for MI/MH service providers on HIV and other sexually transmitted infections.

Across Populations

1. Sustained contact with clients (six or more sessions).
2. HIV training/education for clergy.
3. Increased media support: web pages, billboards, buses, etc.
4. Street outreach that is more comprehensive and intensive.
5. Focus groups to obtain more information from target populations.

Agencies

1. Spanish language training for service providers.
2. Sensitivity training and education for providers on transgender populations and issues.
3. Identify and engage additional minority prevention and health care service providers.
4. Training for educators/providers in non-judgmental communication, homophobia and cultural diversity of MSM lifestyles.
5. Preparation of educators to provide age-appropriate response to HIV/STD and human sexuality questions from youth.

Ranking of Unmet Needs by Youth Roundtables

During the annual youth meeting, the Youth Roundtables were given the task of prioritizing unmet needs for youth. The youth were provided with the list of unmet youth needs as determined by the HCPC. After adding needs that were not previously listed, the youth were instructed to rank each of the needs in priority order. The order was reached through group consensus and modifications were made to the wording of the needs if the youth thought it was necessary. After completing the list, the youth were asked to discuss why their prioritization of needs differed from the HCPC's version. Although the process was informal, the youth provided much input and insight into the HIV prevention needs of Virginia's youth.

Youth Unmet Needs as prioritized by the Youth Roundtable

1. Realistic and consistent sex education in schools, especially for younger grades using an approach that combines abstinence and safer sex messages. This information should also be blended into other topic areas for "real life" skills development. In addition, parent education and communication skills training (through linkages with PTAs and PTOs) should be an integral part of realistic and consistent sex education in schools.

   Discussion: The youth felt that realistic sex education in schools was not enough. All agreed that sex education needed to be realistic *and* consistent. The youth decided that several of the needs on the list needed to be combined into this need as part of the definition of realistic and consistent sex education. HIV education needed to be blended into other topic areas. Also, parent involvement is an important part of

realistic and consistent sex education. The youth strongly encouraged parental involvement in the sex education process.

2. Drop-in Centers.

   Discussion: Drop-in centers were high on the youth's wish list. Although, the youth stated that they did not want adults watching over them, a small amount of adult supervision was necessary. Drop-in centers would provide a place for youth to hang out with friends with minimal adult involvement.

3. Peer education modules that include adult mentors and near-peer mentors.

   Discussion: Peer education was considered to be a very effective method in working with youth. The youth added near-peer mentors along with the adult mentors because they felt that sometimes it is necessary to have a person who is closer in age than an adult.

4. Skills building and negotiation activities with reinforcement for health behaviors and choices. Instill a sense of responsibility and ownership of choices made. Information that should be included is: education on how to access HIV and STD testing, general leadership and development skills, and education on how to access and use condoms.

   Discussion: The youth thought that this need should actually be incorporated into realistic and consistent sex education. However, since these were activities that could happen outside of the school setting, the youth decided to leave them separated. The need of "education on how to access condoms" was modified to include education on how to use a condom as well. Needle exchange and how to clean needles was also discussed as a part of skills building.

5. Transportation to programs.

   Discussion: The youth did not understand why transportation to programs did not score highly when the HCPC originally prioritized youth unmet needs. They felt that rural youth had not been considered when prioritizing this need. Also, sometimes the areas that have relatively good public transportation do not fit the transportation needs of the youth in that area.

The youth were asked to provide discussion on the three needs that were not included in their prioritization. The three needs were top priorities for the HCPC. Although the youth acknowledged that two of the unmet needs (Support and role models for GLBTI youth and programs for gang members and delinquent youth) were important, the five unmet needs ranked highest should include elements of these needs.

1. Support and role models for Gay, Lesbian, Bisexual, Transgender, and Intersex (GLBTI) youth.

   Discussion: The youth decided that sexual orientation was not the reason for needing HIV prevention programs. The opinion of the group was that if Virginia had realistic and consistent sex education programs with appropriate skills building activities, then

sexual orientation would be included. The youth also stated that sexual orientation was more of a value issue with adults than it was with youth.

2. Programs for gang members and delinquent youth.

   Discussion: The youth agreed that this unmet need should be expanded to define program qualities that are needed for gang members and delinquent youth. The youth also felt that gang members and delinquent youth were in a similar category as GLBTI youth; if Virginia had realistic and consistent sex education programs then the needs of these youth would be met.

3. Data on teen behaviors-Youth Risk Behavior Survey implementation.

   Discussion: Initially, the youth did not rank this need as a priority because the group did not know about the Youth Risk Behavior Survey. After explaining what the survey was and how it could be used, the youth still did not think it deserved to be prioritized or even on the list of unmet needs. The overall consensus was that implementation of the survey was a waste of money. The youth did not see implementation of the survey as a link to better quality programs for youth.

VI. Potential Strategies and Interventions

The HCPC, in collaboration with the Survey and Evaluation Research Laboratory, the Virginia Department of Health, Division of HIV/STD, and the VDH prevention contractors developed a taxonomy of interventions for use in defining potential strategies and interventions. The taxonomy was largely devised from CDC's taxonomy document and has been refined several times since it was developed in 1999. The taxonomy was used in development of an evaluation system for contractors as well as to prioritize interventions.

TAXONOMY OF VIRGINIA HIV PREVENTION INTERVENTIONS

CATEGORY I: Counseling, Testing, Referral, Partner Counseling and Referral Services

A. Counseling and Testing: Counseling provides information regarding the acquisition and transmission of HIV, as well as education about the meaning of HIV test results. Client-centered prevention counseling helps clients identify risk behaviors for HIV and assist them in committing to a plan to reduce risk behaviors. Informed consent is required for HIV testing, which provides clients information on their HIV status.

B. Referral: The process by which immediate clients needs for care and supportive services are assessed and prioritized and clients are provided with assistance (e.g. setting up appointments, arranging transportation) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with care and support service providers. Referral does not include ongoing support or case management. Providers should follow-up and document whether the client accessed the referral services.

C. Partner Counseling and Referral Services: PCRS assists HIV-infected clients in notifying their sex and needle-sharing partners. Client referral is used when HIV-infected individuals choose to inform their partners themselves and refer their partners to counseling and testing. The provider should assist the client in developing a plan to inform his or her partners. Provider referral is used when the provider, with the consent of the HIV-infected client, takes the responsibility for contacting the partners and referring them to counseling, testing and other support services. Provider referral allows partners to be notified about their possible exposure without learning the identity of the original client. Provider referral often allows for immediate, on-site counseling and testing services for the partners.

CATEGORY II: Health Education/Risk Reduction

A. Individual Level Intervention (ILI) – Providing one-to-one, personalized education which includes formal/informal assessments and a skills building component. May include HIV/STD awareness, primary and secondary prevention education, and referral. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help make plans to obtain these services.

B. Prevention Case Management (PCM) – A client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. PCM is

indicated for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention intervention addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors. Priority for PCM services should be given to HIV seropositive persons.

C. Group Level Intervention (GLI) - Providing education to two or more individuals in a group setting which includes formal/informal assessments and a skills building component. May include HIV/STD awareness, primary and secondary prevention education, and referral. Health education and risk reduction intervention shifts the delivery of service from individual to groups of varying sizes. Group level education does not include "one-shot" educational presentations or lectures that lack a skills building component.

D. Community Level Intervention - A distinct class of programs characterized by their scope of objectives. A community level intervention is designed to reach a defined community (may be geographic or an identified subgroup) with the intention of altering social norms in that community as a way to influence at risk behavior. A community level intervention may include aspects of other categories, but the combination must be aimed explicitly at community norms in order to be classified as a community level intervention. Community level interventions seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment.

E. Street and Community Outreach – The screening and engaging of individuals for the purpose of delivering primary/secondary prevention education, materials and/or referrals, usually within a specified location and/or community.

i. Basic Street/Community Outreach – Consists primarily of contacts during which outreach workers engage in brief conversations, providing information, literature, condoms, referrals, etc. This type of outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, prevention case management, home health parties, and peer education groups. Basic outreach cannot be expected to change behaviors in and of itself, and should not be considered an intervention.

ii. Intensive Street/Community Outreach – Includes ongoing encounters in which outreach workers spend extended periods of time with clients, assess risks, make plans with clients for behavior change, and provide referrals. The outreach worker and client meet on multiple occasions. Outreach workers may also facilitate clients' entrance into services and should verify follow-through on referrals when possible. Both process and outcome evaluation should be used in assessing this type of outreach. (The conditions of Basic Outreach must be met.)

iii. **Collaborative Street/Community Outreach** – An outreach effort that utilizes outreach workers from various agencies and other health care providers to participate in a tabling or stroll of an already identified and assessed area for the purpose of saturating the area with specific information, (e.g., a major syphilis outbreak has occurred in a residential area; the health department will be providing on-site testing; outreach workers would then be pivotal in disseminating information and directions about the testing.) Collaborative outreach is a strategy or method for conducting basic and/or intensive outreach, and should not be considered an intervention.

CATEGORY III: Health Communication/Public Information

The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain services.

A. Presentations/Lectures – These are information-only activities conducted in group settings; often called "one-shot" or "AIDS 101" education interventions.

B. Health/Community Fairs – To set up information tables or booths which may include interactive activities for the purpose of disseminating verbal and written information to the general public and/or high-risk populations. Health/community fairs raise awareness and assist in building relationship within a community. May be used as a vehicle to recruit persons for other services/programs.

C. Mass Media – Use of the media to reach the public or targeted populations. (Includes television, radio, print, and the internet.) The use of print, radio, television or the internet to advertise an event or agency should not be considered a mass media campaign.

D. Hotlines – Interactive electronic outreach systems using telephones, computers and mail to provide a responsive information service to the general public as well as high-risk populations.

E. Clearinghouse – Interactive electronic outreach systems using telephones, mail, and the internet to provide a responsive information service to the general public, as well as high-risk populations.

F. Social Marketing – Social marketing is a form of community-level intervention which uses techniques adapted from commercial marketing to identify specific audiences called segments, identify their perceived needs, and then construct a program of services, support and communication to meet those perceived needs.

STANDARDS FOR HIV PREVENTION

Counseling and Testing Standards

1. Staff/agencies conducting HIV testing should adhere to the Centers for Disease Control and Prevention's Revised Guidelines for HIV Counseling, Testing and Referral issued November 9, 2001, the Revised Guidance for Partner Counseling and Referral Services issued and any additional guidance or standards prescribed by VDH.

2. Curricula for prevention counseling should address cultural competency issues as they affect HIV counseling and testing.

3. All persons who provide HIV prevention counseling should complete the three-day CDC prevention counseling courses, "The Facts" and "The Fundamentals", as well as the "Partner Counseling and Referral Services" course. Health department personnel should be involved in providing some components of the prevention counseling course.

4. Counseling and testing providers should use a non-judgmental client-centered approach.

5. Informed consent should be obtained prior to testing.

6. Policies and procedures to ensure patient confidentiality must be a priority.

7. Test results should be provided in person, whether the client tested negative or positive.

8. Persons who test positive should be immediately linked to care and support services.

9. Program reviews with health districts should include verification that skills inventories of health counselors have taken place, as recommended.

10. Program reviews with health districts should include assessment of implementation of both CDC and VDH standards.

Individual Level Intervention Standards

1. The intervention should be client driven.

2. The intervention should target a specific behavior.

3. The intervention should include a risk assessment and a skills building component.

4. The provider and client should develop an action plan or goal that identifies desired outcomes.

5. Client rights and responsibilities should be established prior to the start of the intervention (e.g. confidentiality).

6. The intervention should be provided in an nonjudgmental manner (i.e. a safe space).

7. To the extent possible, the physical environment should be accessible and acceptable to the individual.

8. Individual level interventions should include an evaluation component.

9. The plan developed should be appropriate for the culture and language of the client.

10. Staff conducting individual level interventions should be trained in counseling.

11. Agencies should strive to achieve cultural congruence between the facilitator and clients when feasible. This congruence may include the following: race, ethnicity, primary language, gender, HIV status, etc.

Prevention Case Management Standards (for HIV Prevention Programs)

Prevention Case Management (PCM) is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. PCM is indicated for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention intervention addresses the relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors. Priority for PCM services should be given to HIV seropositive persons.

<u>Client Recruitment and Engagement</u>

- Protocols for client engagement and related follow-up should be developed, such as requiring a minimum number of follow-up contacts within a specified time period.

<u>Screening and Assessment</u>

- PCM program staff should develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate for PCM.
- All persons screened for PCM, including those who are not considered to be appropriate clients for PCM, should be offered counseling by the prevention case manager (or other staff) and referrals relevant to their needs.
- Thorough and comprehensive assessment instrument(s) should be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- All PCM clients should participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs.

- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

Development of a Client-Centered Prevention Plan

- For each PCM client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving anti-retroviral or other drug therapies, the Prevention Plan should address issues of adherence.
- The Prevention Plan should address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.
- For clients with substance abuse problems, the Prevention Plan should address referral to appropriate drug and/or alcohol treatment.
- Clients should sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- Client files that include individual Prevention Plan must be maintained in a locked file cabinet to ensure confidentiality.

HIV Risk-Reduction Counseling

- Multiple-session one-on-one HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients. Sessions should be flexible to address the needs of the clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status should receive information regarding the potential benefits of knowing their HIV serostatus.
- Clients should be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of STDs.
- PCM program staff should develop a protocol for assisting HIV seropositive clients in confidentiality notifying partners and referring them to PCM and/or counseling and testing services.
- For persons receiving treatment for opportunistic infections and/or anti-retroviral therapy(ies), counseling to support adherence to treatments/therapies should be provided.

Coordination of Services with Active Follow-Up

- Formal and informal agreements, such as memoranda of understanding, should be established with relevant service providers to ensure availability and access to key service referrals.
- A standardized written referral process for the PCM program should be established. A referral tracking system should be maintained.
- Communication with other providers about an individual client is dependent upon the obtainment of written, informed consent from the client.

- A mechanism to provide clients with emergency psychological or medical services should be established.

Monitoring and Reassessing Clients' Needs and Progress

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
- A protocol should be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."

Discharge from PCM upon Attainment and Maintenance of Risk-Reduction Goals

- A protocol for client discharge must be established.

Staff Qualifications

- Suggested Minimum Qualifications: A bachelor's degree or extensive experience in a human services-related field, such as social work, psychology, nursing, counseling, or health education; skill in case management and assessment techniques; skill in counseling; ability to develop and maintain written documentation (case notes); skill in crisis intervention; knowledgeable of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change principles and strategies; and cultural and linguistic competence. Staff without degrees or extensive experience should receive supervision and guidance from a licensed professional.
- Staff must be provided written job descriptions and opportunities for regular constructive feedback. In addition, staff should be provided opportunities for regular training and development.
- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures. PCM staff should have signed confidentiality agreements on file with their employer.

Coordination of PCM with Ryan White CARE Act Case Management

- A protocol for structuring relationships with Ryan White CARE Act case management providers should be established and should detail how to transfer and/or share clients.
- PCM should not duplicate Ryan White CARE Act case management for persons living with HIV, but PCM may be integrated into these services.

Quality Assurance

- Clear procedure and protocol manuals for the PCM program should be developed to ensure effective delivery of PCM services and minimum standards of care.
- Written quality assurance protocols should be developed and included in procedure and protocol manuals.
- Client PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's signature.

Standards for Ethical and Legal Issues

- **Confidentiality.** Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conform to state and federal laws. These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed, and/or participate in PCM.
- **Voluntary and Informed Consent.** A client's participation must always be voluntary and with the client's informed consent. Documentation of voluntary informed consent must be maintained in the client's file. In addition, a client's informed consent in required before a prevention case manager may contact another provider serving that same client.
- **Harm Reduction.** PCM staff should utilize principles of harm reduction. Harm reduction is a set of practical strategies that reduce negative consequences of drug use or other risk behaviors, incorporating a spectrum of strategies from reducing risks to abstinence. Harm reduction strategies meet clients "where they're at," addressing conditions of use along with the use itself.
- **Cultural Competence.** Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population. Cultural appropriateness and relevance are critical to the success of any HIV prevention activity.
- **Professional Ethics.** Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).
- **Duty to Warn.** Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger.

Group Level Intervention Standards

1. There should be a commonality or link between participants that identifies them as members of the group.

2. The intervention should target a specific behavior or behaviors.

3. The intervention should include a risk assessment and a skills building component.

4. The provider should obtain or develop a curriculum for the intervention that defines the goals and objectives of the program.

5. Ground rules addressing attendance, participation, honesty, trust and confidentiality should be established with the participants at the start of the intervention.

6. The intervention should be provided in an nonjudgmental manner (e.g., a safe space).

7. To the extent possible, the physical environment should be accessible and acceptable to the population.

8. Multiple session group level interventions should include an evaluation component.

9. The curriculum selected should be appropriate for the culture and language of the participants.

10. Staff conducting group level interventions should be trained in group facilitation skills.

11. Agencies should strive to achieve cultural congruence between facilitator and participants when feasible. This may include any or all of the following: race, ethnicity, primary language, gender, HIV status, etc.

Street and Community Outreach Standards

The following definitions are described in Planning and Conducting Street Outreach Process Evaluation from the Centers for Disease Control and Prevention, U.S. Public Health Service.

Active Street Outreach: Outreach specialists moving down a street, screening and engaging prospective clients for the purposes of delivering information, materials and/or referrals. Active outreach is usually location specific, occurring within a few blocks radius or within a specific neighborhood.

Fixed Site Outreach: Outreach activities which are conducted at a specific place within a given location (e.g., setting up a table on a corner or working out of a mobile van or storefront). During fixed site outreach, outreach specialists may invite persons whom they have engaged in the street to come to the site or place for more in-depth assessment discussions and/or service delivery, based upon client needs or interests.

Drop Off Site Outreach: Outreach activities which provide risk reduction supplies to volunteer distributors who may then distribute these items to persons involved in risk behaviors (e.g., brochures left at a checkout counter or bleach kits distributed at an injection drug user "shooting gallery").

Contact: Face-to-face interaction during which materials and/or information is exchanged between an outreach specialist and a client (or a small group of clients).

Encounter: Face-to-face interaction that goes beyond the contact to include focused assessments, specific service delivery in response to the client's identified need(s), and a planned opportunity for follow-up.

The remaining terminology was developed by the Division of HIV/STD, its contractors, the VCU Survey and Evaluation Laboratory and the Virginia HIV Community Planning Committee.

Basic Street/Community Outreach: Consists primarily of contacts during which outreach specialists engage in brief conversations, providing information, literature, condoms, bleach kits, referrals, etc. This type of outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, prevention case management, home health parties, and peer education groups. Basic outreach cannot be expected to change behaviors in and of itself, and should not be considered an intervention.

Intensive Street/Community Outreach: Includes ongoing encounters in which outreach specialists spend extended periods of time with clients, assess risks, make plans with clients for behavior change, and provide referrals. The outreach specialist and client meet on multiple occasions. Outreach specialists may also facilitate clients' entrance into services and should verify follow-through on referrals when possible. Both process and outcome evaluation should be used in assessing this type of outreach. (The conditions of Basic Outreach must be met.)

Collaborative Street Outreach: An outreach effort that utilizes outreach specialists from various agencies and other health care providers to participate in a tabling or stroll of an already identified and assessed area for the purpose of saturating the area with specific information (e.g., a major syphilis outbreak has occurred in a residential area; the health department will be providing on-site testing; outreach specialists would then be pivotal in disseminating information and directions about the testing). Collaborative outreach is a strategy that may combine basic and intensive outreach and should not be considered an intervention on its own.

Safety

1. Outreach should be conducted in pairs. Individuals should not go out alone.

2. Supervisors should be informed about the areas to be targeted each session.

3. Outreach specialists should carry personal identification, agency identification and clothing that identifies them as an outreach specialist or agency staff person.

4. Before beginning outreach activities, staff should familiarize themselves with local law enforcement. Staff should be introduced to police officers at muster so that police understand their role in the community and do not mistakenly identify outreach specialists as drug dealers, etc. Involvement with the police department through a liaison or training should be established.

5. Outreach specialists should never buy from or sell anything to street contacts.

6. Agencies should establish "no weapons" policy while staff are conducting outreach.

7. Agencies should establish a communications, tracking and/or emergency plan for street outreach specialists.

Qualifications

1. Outreach specialists with a history of substance abuse should have a minimum of two years sobriety. This avoids putting individuals in situations that could trigger old behaviors while they are vulnerable to relapse.

2. It is more important for outreach specialists to be skilled in counseling, cultural competency, substance use/abuse, and have the ability to develop rapport with clients than to be indigenous to the community or neighborhood or population being targeted.

Training

Outreach specialists should be provided with the same opportunities as other health educators for professional development and training.

1. Outreach specialists should receive training in the following areas: HIV, STDs, substance abuse, mental health issues, counseling skills, availability of local resources, values clarification, human sexuality and homophobia, behavioral science and the language of HIV prevention.

2. Agencies should establish support mechanisms for outreach specialists, especially those in recovery. A staff person or other professional resource should be identified for support and referral into relapse prevention, 12 Step or other programs.

3. Outreach supervisors should participate in training along with their staff in order to understand the nature of the outreach specialist role and be available to provide adequate professional support.

4. Outreach supervisors should share information about objectives and grants for which outreach is being conducted and educate staff about the types of data to be collected.

In addition to standards for interventions, the HCPC has also developed standards for the minimum training needed by HIV educators and suggested guidelines for content of a basic HIV/AIDS presentation.

HIV Educator Standards

1. HIV educators should receive a minimum of four hours of training on a quarterly basis in one or more of the following areas: HIV/AIDS including clinical issues, sexually transmitted diseases, counseling and testing procedures and laws, tuberculosis, viral hepatitis, human sexuality, reproductive health and birth control, substance abuse, mental health, racism, cultural sensitivity, classism and homophobia. Employers shall document training(s) in employment records.

2. HIV educators should understand the basics of behavioral science theory.

3. HIV educators should have counseling and facilitation skills.

2. HIV educators should be able to conduct a sexual and drug use history and risk assessment and help clients develop a risk reduction plan.

3. HIV educators' dress, demeanor and communication skills should be appropriate to the situation and program participants.

4. HIV educators should not engage in inappropriate or sexual relationships with program participants.

5. HIV educators should be able to refer participants to clinical care, drug treatment and other community services.

6. HIV educators should have appropriate formal education, and/or practical knowledge and experience, adequate to perform expected duties.

HIV/AIDS "101" Standards

Basic Information to be Covered

What are HIV and AIDS?

HIV-Human Immunodeficiency Virus
How the virus attacks the body and immune system
The role of the immune system and antibodies
Spectrum of Disease: Progression from HIV to AIDS
AIDS-Acquired Immunodeficiency Syndrome
Opportunistic Infections
Currently no cure or vaccine

Transmission

Most common body fluids that transmit HIV are: blood, semen, vaginal fluids and breast milk; any body fluid that contains visible blood
Perinatal transmission
Routes of transmission include:
Sharing needles/syringes
Unprotected vaginal, oral and anal sex
Receipt of infected blood, blood products, tissues or organs (very rare)

Myths and Misconceptions

Casual Contact: eating, drinking, air, toilet seats, attending school or working with someone who has HIV

Body fluids that do not transmit HIV: saliva, sweat, urine

Mosquitoes
Low risk from blood transfusions
No risk from donating blood
Urban Legends (needles in phone booths, movie theater seats, gas pump handles
Welcome to the World of AIDS, semen/blood put in food at fast food restaurants)

Prevention

Abstinence from sex and drug use
Monogamous sexual relationship between two uninfected people
Sex that does not involve exchange of body fluids
Not sharing needles/syringes and other drug paraphernalia
Cleaning needles/syringes and other drug paraphernalia
Barrier sex: using condoms, dental dams and/or other barriers consistently and correctly
Not sharing sex toys
Cleaning sex toys

(Time permitting and depending on the audience, educators can demonstrate proper condom usage and/or needle/syringe cleaning)

Knowing Your Status

Antibody Testing: Elisa and Western Blot
Window period for antibody testing: 8-24 weeks, average 12 weeks
The difference between anonymous and confidential testing
HIV positive does not mean you have AIDS
Availability of treatment to slow disease progression
Importance of testing for pregnant women

Resources

Hotlines
Test Sites
Local Health Departments
Community Based Organizations
Web Sites

Standards for Adults Working with Youth

The Standards for Adults working with Youth were developed during the annual meeting of the three youth roundtables.

Qualities of youth programs

- **Be fun and interactive.** Youth are more likely to be involved and stay active if the program is interesting and fulfilling.
- **Adults should know the information.** The fastest way to lose respect with youth is to not know your subject area. Would you take advice from someone who didn't know what they were talking about?
- **Stay on topic.** The youth are here for a reason, stay with that reason.
- **Bring food or other incentives.** Bring food and they will come.
- **Follow up with the group.** Following up helps youth feel involved in the process.

Communication is the key

- **Listen.** Although you may *hear* the words youth are saying, listening and understanding is different. Ask for clarification. Youth are experts about their life; you're not, so **listen**.
- **Be Respectful.** You have to give respect to get respect.
- **Don't talk at youth, but with them.** Make it a conversation, not a lecture.
- **Use language that relates to youth.** Don't try to put all the slang words you know into one sentence, but using some slang decreases how clinical you sound. Only use terms that you are comfortable using. This also allows youth to use words they are comfortable with in the discussion.
- **Don't get personal.** This can go two ways. 1) Life isn't always about you. Don't share your personal story unless asked. 2) Don't force youth to share their personal history.
- **Use gender-neutral terms.** Don't make assumptions about gender.
- **No labeling.** Remember that we are all individuals.
- **Non-judgmental.** Your role is not to push your personal values by judging the youth. Be respectful of their right to have their own opinions.

Qualifications for Adults working with youth

- **Be able to relate to youth.** If you can't remember what it's like to be a youth, maybe working with youth is not the path to take.
- **Be mature.** Being able to relate to youth doesn't mean acting their age.
- **Be open-minded.** Being a youth in today's world is different than when you were a youth. Be open-minded to what may have changed.
- **Be patient.** It takes time to develop trust and rapport with youth. Take the time to make an effort without expecting too much.
- **Don't push your personal values.** Everyone is different. Allow youth the chance to develop their personal values, not yours.
- **Don't be hypocritical.** If you want to maintain a respectful relationship with youth, you must be able to walk the walk.

VII: Priority Setting for Interventions

Priority Setting for Interventions was undertaken in summer 2003. To prepare for this process and ensure that all members understood the task, the HCPC reviewed the elements of Comprehensive Plan, CDC Guidance, and the 2000 prioritization process.

Selecting Criteria/Factors

Criteria to be considered for use in prioritization were gleaned from several sources:

- The Guidance for HIV Prevention Community Planning
- Setting HIV Prevention Priorities: A Guide for Community Planning Groups, *Academy for Educational Development Center for Community Based Health Strategies*
- Factors Used in Virginia's 2000 Prioritization Process
- Brainstorming by Committee members

The HCPC reviewed the list of possible factors generated during the 2000 prioritization process to determine if any other factors needed to be considered. Through a consensus decision model, the decision was to retain the factors used in the 2000 prioritization process.

Methodology based on 2000 Prioritization Process

During prioritization of interventions in 2000, a list of possible factors was generated and through group consensus, several overlapping categories were collapsed to create the following questions:

Is the intervention ethical?
Does the intervention target a specific population?
Does the intervention target a specific behavior that will change as a result of the intervention?
Are there indicators of outcome effectiveness?
Was the intervention developed with input from the target population?
Is the intervention sustainable?
Is there capacity to provide the intervention?
Is there a theoretical basis for the intervention?
Is the intervention cost effective?
Does the intervention meet the norms, values, and consumer preferences of the community?
Does the intervention address a high priority need?
Is the intervention feasible?
Is the intervention accessible to the target population?
Is the intervention legal?

This list of factors was considered too large and unwieldy for prioritization. The Committee further discussed the meaning of each of the questions posed and by consensus selected the

factors to be included. If any member disagreed with the designation of a particular factor, the Committee stopped and discussed the item again until agreement was reached.
Several of the factors were determined to characterize the way an intervention was conducted or carried out by a provider rather than being a characteristic the intervention itself. These factors cannot be expected to remain constant across all conditions, but will vary depending on the work plan and who the agency and staff that are providing them. Accordingly, the Committee then designated these factors to be used by VDH in scoring proposals for HIV prevention funding through the Request for Proposals (RFP) process. These factors were moved to the RFP list upon of agreement of all participants. One factor, *Is the Intervention Legal*, had only a yes or no answer possible and was also moved to the RFP list, as it did not seem relevant to deciding what should be funded. Regardless of the legality of an intervention, such as needle exchange, the HCPC decided the interventions should be prioritized on their merits and that legal issues should be left for VDH to address in the funding process. One factor, *Does the intervention target a specific population?* caused extended discussion. It was finally determined that this also could be a "gatekeeper" issue. The funding entity must ensure that agencies submitting proposals are specific about the recipients of intended interventions.

Factors to be Considered in RFP Criteria

Is the intervention ethical?
Was the intervention developed with input from the target population?
Is the intervention sustainable?
Is there capacity to provide the intervention?
Is the intervention feasible?
Is the intervention accessible to the target population?
Is the intervention legal?
Does the intervention target a specific population?

This left the following six factors to be used in the prioritization process:

Does the intervention target a specific behavior that will change as a result of the intervention?
Are there indicators of outcome effectiveness?
Does the intervention meet the norms, values, and consumer preferences of the community?
Is there a theoretical basis?
Is the intervention cost effective?
Does the intervention address a high priority need?

The next step in the process was to weigh each of the selected factors and determine a scoring range. In 2000, the Committee decided to use a range of 0-5 in scoring each factor. This did not change for the 2003 process. Also in 2000, the Committee weighted each factor on a scale of 1 to 3, as multiplying by each successive number represents an exponential increase in the final score. After much debate, the Committee agreed to change the weights to 1 and 2. The weights were then applied to the six factors using a consensus model. This proved somewhat problematic as the smaller range of numbers made differentiation between intervention scores difficult to discern. For example, it was difficult to reach an agreement about not including needle exchange as a prioritized intervention for racial and ethnic minorities because the score

difference was so close to the previous intervention. The factors were also shortened from a full question to a brief phrase for the actual ranking process.

2003 Factors and Weights

Factor	Weight
Target a specific behavior	**1**
Indicators of outcome effectiveness	**2**
Norms, values and consumer preferences	**2**
Addresses a high priority need	**2**
Theoretical basis	**2**
Cost benefit	**1**

The next step in conducting the intervention prioritization was determining the list of interventions to be used from the Taxonomy. Most of the selection was straightforward; however, certain specific items were collapsed under public information, and oral HIV testing was specified. Although listed in the Taxonomy, basic street outreach was not included as it is considered a necessary element of conducting other forms of street and community outreach but should not be funded as an intervention in and of itself. Additional items such as needle exchange were listed at Committee members' requests. Collaborative street outreach was not included in the 2003 list due to revising the Taxonomy and eliminating it as an intervention. A final list of thirteen interventions was developed.

Interventions to be Prioritized

Individual Level Intervention
Prevention Case Management
Group Level Intervention
Traditional Counseling, Testing, Referral and Partner Counseling and Referral Services (CTRPCRS)
Oral HIV Testing (Oral CTRPCRS)
Mass Media
Social Marketing
Community Mobilization
Hotlines
Lectures/Presentations
Intensive Street Outreach
Facilitative Street Outreach*
Needle Exchange

*Although facilitative outreach was prioritized and ranked during this process, it has since been collapsed into intensive outreach. It remains as ranked in this document. The change will be incorporated in 2004.

Rapid testing plans are just being formulated in Virginia; therefore, rapid testing was not included in the process. This will also be updated in 2004.

The final step in preparation for conducting prioritization was determining the method for assigning scores. In order to achieve consistent scoring across populations and make the task more manageable, the HCPC divided into two working committees: Research, and Standards & Practices. The Research Subcommittee, which has expertise in behavioral science theories, agreed to score the three factors related most to research: Indicators of Outcome Effectiveness, Theoretical Basis and Cost Benefit. The Standards and Practices Subcommittee, which has expertise in working directly with affected communities and hands-on provision of prevention education, agreed to score the remaining three factors: Targets a Specific Behavior, Norms, Values and Consumer Preferences, and Meets a High Priority Need.

The Committee used a number of documents in the scoring process.

- Bibliography and abstracts of intervention effectiveness research compiled by the SERL
- Compendium of HIV Prevention Interventions with Evidence of Effectiveness compiled by CDC
- Prioritized Unmet Needs developed by the HCPC in 2002
- Center for AIDS Prevention Studies Fact Sheets
- Member Expertise

The two subcommittees, over the course of two meetings, prioritized each of the 13 interventions by each of the seven priority target populations and one un-prioritized population of special interest.

Prioritized Interventions by Target Population

Persons Living with HIV/AIDS

1. **Prevention Case Management**
   Allows the opportunity to deal holistically with complex issues regarding prevention. Clients can be assisted in addressing barriers that hamper the acceptance of safer behaviors. This is especially important for clients previously counseled who continue to engage in high risk behaviors. It can also contribute to improved health outcomes, such as lowered viral load, through medication adherence.
2. **Individual Level Intervention**
   Allows clients to deal with multiplicity of issues surrounding positive status. In addition, it provides confidentiality for clients who fear disclosure of their status.
3. **Group Level Intervention**

Provides a supportive peer environment for individuals who may feel isolated by their disease.

4. **Needle Exchange**
   Eliminating needle/syringe sharing by IDUs with HIV is vital to reducing new HIV infections.

5. **Oral HIV Testing**
   Provides services to partners of PLHA who have not been tested and are unlikely to look for other testing resources such as the health department.

6. **Testing, Referral and Partner Counseling and Referral Services**
   Traditional testing provides the opportunity of partners of PLHA who have not been tested to be tested. In addition, PLHA's may use the partner referral services offered to inform partners.

Racial and Ethnic Minorities

1. **Facilitative Street Outreach**
   Those clients with lack of resources such as transportation distrust of the public health system, or language barriers may need assistance in referral follow-through and access to services.

2. **Social Marketing**
   Can target behaviors and populations specifically.

3. **Intensive Street Outreach**
   This intervention has been highly accepted by African American communities provided that outreach specialists are culturally competent. It also reaches clients who may not present for more traditional services.

4. **Community Mobilization**
   The need for HIV prevention efforts to come from within racial/ethnic minority communities and for community leaders to step forward was a salient issue in the HCPC's needs assessment process. Model used in faith initiative programs.

5. **Prevention Case Management**
   Allows for the opportunity to deal holistically with complex issues regarding prevention. Clients can be assisted in addressing barriers that hamper the adoption of safer behaviors. This is important for racial/ethnic minorities who may be economically disadvantaged, have poor access to care, etc.

6. **Oral HIV Testing**
   Highly acceptable to the target population. Provides services to individuals who have not been tested and are unlikely to go to the health department.

7. **Individual Level Intervention (tie)**
   Allows clients to deal with multiple issues such as homelessness, substance abuse, etc. Provides confidentiality for clients who fear disclosure of risk factors.

7. **Group Level Intervention (tie)**

Most effective if multiple sessions are used. GLIs are more effective if gender specific, especially in cultures (Hispanic and Asian/Pacific Islander) in which sexuality is not discussed between the sexes.

7. **Mass Media (tie)**
   Can be used to reach a wider area of targeted populations through means such as radio, television, and internet.

Injecting Drug Users

1. **Needle Exchange**
   Multiple studies support the efficacy of this intervention without an increase in drug use or discarded needles.
2. **Intensive Street Outreach (tie)**
   Effective for reaching IDU not in treatment. Peer led or indigenous health outreach models have proven successful.
2. **Facilitative Street Outreach (tie)**
   Most effective for reaching IDU not in treatment. Peer led or indigenous health outreach models have proven successful.
3. **Prevention Case Management**
   Allows the opportunity to deal holistically with complex issues regarding prevention. Clients can be assisted in addressing barriers that hamper the acceptance of safer behaviors. It is especially important for clients previously counseled who continue to engage in high risk behaviors. In addition, it can contribute to improved health outcomes through behavior modification such as decreased injection drug use.
4. **Individual Level Intervention (tie)**
   Allows clients to deal with issues other than substance abuse such as homelessness. Also, provides confidentiality for clients who fear disclosure of risk factors.
4. **Oral HIV Testing (tie)**
   Provides services to individuals who have not been tested and are unlikely to go to the health department. Assists in testing IDU with poor veins or former IDU who are fearful of needles.

Men who have Sex with Men

1. **Oral HIV Testing (tie)**
   Provides services to individuals who have not been tested and are unlikely to go to the health department.
1. **Community Mobilization (tie)**
   Can target behaviors specifically. Shown to be successful in changing behaviors among MSM communities
2. **Group Level Intervention**
   GLIs with multiple sessions have been effective in reducing high-risk behavior among MSM. Supportive peer environment is an important factor.

3. **Social Marketing**
   Can target behaviors specifically. Shown to be successful in changing behaviors among MSM communities

4. **Prevention Case Management**
   Allows for the opportunity to deal holistically with complex issues regarding prevention. Clients can be assisted in addressing barriers that hamper the acceptance of safer behaviors. Important for high-risk MSM who have not changed behavior despite ongoing prevention. PCM provides an environment for addressing co-factors such as substance abuse, sexual addiction, depression and other factors prevalent in high-risk MSM.

5. **Individual Level Intervention**
   Can be useful for men who are not comfortable discussing sexual issues in a group environment.

6. **Testing, Referral and Partner Counseling and Referral Services**
   Traditional testing provides the opportunity for men who have not been tested to be tested. In addition, partner referral services may be used to inform partners.

Heterosexuals

1. **Group Level Intervention**
   Numerous research articles show these interventions to be effective especially when the women share characteristics and the group size is small.

2. **Testing, Referral and Partner Counseling and Referral Services (tie)**
   Traditional testing provides the opportunity for people who have not been tested to be tested. In addition, partner referral services may be used to inform partners.

2. **Social Marketing (tie)**
   Can target behaviors and sub-populations specifically. Can be effective when working with pregnant women.

3. **Mass Media**
   Can be used to reach a wider area of targeted populations through means such as radio, television, and internet.

4. **Oral HIV Testing**
   Highly acceptable and accessible for a population of women who are unlikely to present for prevention services through other venues or because of child care and transportation cannot access services

Inmates

1. **Prevention Case Management**
   Allows for the opportunity to deal holistically with complex issues regarding prevention. Clients can be assisted in addressing barriers that hamper the acceptance of safer behaviors. This may be especially important for individuals about to be released who must negotiate behavior on the outside.

2. **Group Level Intervention**
   Shown to be effective in reducing risk behaviors especially combined with substance abuse treatment.
3. **Testing, Referral and Partner Counseling and Referral Services**
   Testing is in great demand among incarcerated populations but either costs the inmate money (state prisons) or is denied (some local jails that cannot afford HIV medications)
4. **Individual Level Intervention**
   Offers opportunity for inmates who are concerned with confidentiality and reluctant to join the "AIDS group" for fear of being labeled as HIV infected.
5. **Oral HIV Testing**
   Highly acceptable to the population. Efficient way to conduct HIV testing among clients who cannot present to the health department clinic for blood testing.
6. **Needle Exchange**
   Although drug use is not permitted in correctional facilities, injection drug use is high among the incarcerated population. Additionally, in spite of the lack of formal tattooing and piercing, inmates find innovative methods to tattoo and pierce themselves in correctional facilities.

Youth

1. **Facilitative Street Outreach**
   Youth may have little experience negotiating health systems and have few resources
2. **Group Level Intervention (tie)**
   Multiple sessions provide the opportunity for skills building. Peer and near peer education and programs in juvenile detention centers provide opportunities for GLIs.
2. **Social Marketing (tie)**
   By identifying specific segments of the youth population (e.g. runaways, GLBTQ, homeless), specific programs can be constructed based on that groups specific needs and not follow a "one size fits all" idea in programming.
3. **Oral HIV Testing (tie)**
   Highly acceptable and accessible for a population who may not have transportation, may be reluctant to seek out testing or may not follow though on intention to get tested.
3. **Intensive Street Outreach (tie)**
   Important for reaching high-risk youth such as out of school, run away, gang members and sex workers.

Transgender

1. **Group Level Intervention (tie)**
   Multiple sessions provide the opportunity for skills building. Peer led programs may provide a comfort level of confidentiality for clients.
1. **Oral HIV Testing (tie)**

Highly acceptable and accessible for a population who may not have transportation, may be reluctant to seek out testing or may not follow though on intention to get tested.

1. **Community Mobilization (tie)**
   The need for HIV prevention efforts to come from within the Transgender community and for community leaders to step forward was a significant issue in the HCPC's needs assessment process.

1. **Intensive Street Outreach (tie)**
   Important for reaching a population that may not present themselves in traditional service areas. Outreach specialists must be culturally competent in addressing this population. Also, reaches transgender individuals who support themselves as sex workers.

2. **Needle Exchange**
   Transgender populations use needles to inject hormones and silicone. Oftentimes, needles are shared to inject substances that are not supervised by a medical doctor. In addition, hormones are suspended in an oil-based solution that makes cleaning needles difficult with a bleach and water solution. Although the main use of needles in transgender populations is for hormone injections, this does not exclude injection drug use.

3. **Individual Level Intervention**
   Allows clients to deal with multiple issues such as homelessness, substance abuse, etc. Provides confidentiality for clients who fear disclosure of risk factors.

4. **Prevention Case Management**
   Allows for the opportunity to deal holistically with complex issues regarding prevention. Clients can be assisted in addressing barriers that hamper the adoption of safer behaviors. This is important for transgender populations who may have mental health issues, poor or no access to medical care, or substance abuse issues.

General Discussion

A number of interventions such as mass media, hotlines, lectures and presentations etc. did not score highly for any of the targeted populations or were excluded from consideration, as was basic street outreach. While these interventions may not be valid strategies for changing behavior, they still have an important role in the spectrum of HIV prevention services.

Hotlines, for instance, provide an important link between the public and a vast array of services. The state hotline provides referrals for anonymous and confidential testing, support services, health care, legal services etc. It may be the first link a caller who is at risk, infected or a family member/significant other has in obtaining services in their community. It also provides an anonymous method of obtaining information about HIV. Hotlines can also serve as a clearinghouse for providers.

Media campaigns, posters, pamphlets, billboards etc. are not likely to change behavior but they may raise awareness, help personalize risks, and provide linkages to both prevention and care services.

Lectures and presentations, (typically AIDS 101) provided in workplaces and other venues may reach individuals who do not identify with a specific population at risk due to stigma, denial etc. These presentations may be the only venue in which they receive prevention education. In addition, CBOs can successfully establish linkages with agencies that invite them in for a one-hour presentation for their clients. This often is the first step in establishing rapport, demonstrating the services that can benefit the clients and obtaining agreement to start conducting a "real" intervention.

As mentioned earlier, basic street outreach is not expected to change behavior but is a necessary step in conducting intensive outreach and helps establish rapport within a community.

While these approaches should not be accorded the value of the prioritized interventions, it should be recognized that they are often necessary elements in a comprehensive prevention program.

Characteristics of Effective Prioritized Interventions

The HCPC also recommended that VDH consider in proposal reviews that interventions are most effective when:

- they are provided in a culturally and linguistically appropriate manner,
- they are gender specific,
- a peer group or opinion leader is involved in the provision of the intervention,
- provides multiple sessions with the clients.

VIII: Goals

This chapter describes general long and short-term goals for improving Virginia's HIV prevention program. The goals are stated in broad-based and thematic terms rather than as measurable objectives. The goals were derived from a number of sources utilized by the HCPC in developing this plan including: the epidemiology of HIV and AIDS, the prioritized unmet needs of the target populations, input from agencies and individuals who attended public hearings, barriers and deficiencies identified through population-based research, and the organizational survey.

Some of the goals reflect activities that can be addressed through increased funding or specific population and interventions, training and capacity building among providers, or improved linkages among existing resources. Other goals reflect a need for system-wide changes and removal of political, social, and legal barriers. The Virginia Department of Health and its contractors may not have the ability to meet or bring about the changes needed to meet all of these goals; however, these goals are presented to represent a holistic approach to improving HIV prevention interventions for persons at-risk.

Previous Goals from 2000 HIV Prevention Comprehensive Plan

The following are the goals established in the 2000 HIV Prevention Comprehensive Plan and the status of those goals.

Long Term Goals

Programmatic Goals

- Increase the number of persons who return for test results and post test counseling.

Status: In 2000, the percent of people returning for HIV test results and post test counseling for confidential and anonymous state funded HIV testing and counseling was 36.2%. This percentage decreased to 34.4% in 2001 and increased to 37.6% in 2002. While these numbers are higher than those in the late 1990s, it is disappointing that less than 50% of those tested received their test results. The implementation of rapid testing in high-risk populations should help alleviate this problem.

- Increase HIV testing among persons not previously tested.

Status: In order to establish a baseline for this goal, the HIV testing slips were updated in 2001 to include information on previous testing of clients. Use of the new lab slip began in October, 2001; therefore, a baseline could not be established until 2002. For 2002, the total number of people tested for the first time was 20,158 (25.5%) and seventy-one (0.4%) of those tested positive. Only 41.4% of those first-time testers received post-test counseling and forty-two (59.2%) of the positive testers received post-test counseling.

- Improve quality assurance activities for counseling, testing, referral and partner counseling and referral.

Status: Quality assurance activities were greatly impacted by the decentralization of the Disease Intervention Specialist positions. In view of CDC's new initiative focusing on testing and the availability of rapid testing, VDH has taken a closer look at the counseling and testing program. With the implementation of OraSure testing and the pending implementation of rapid testing, VDH will need to dedicate more staff and staff time to ensuring that counseling and testing is conducted according to CDC standards and recommendations.

- Ensure that all persons conducting street outreach have received adequate training and completed a standardized curriculum on street outreach.

Status: The Division developed and implements an annual 4-day intensive street outreach training for street outreach workers and their supervisors. The training has been modified each year based on feedback from contractors and the trainers. All contractors who receive funds for street outreach are required to send all employees who conduct street outreach and their supervisors to this training. Annual training does not meet the demand for this course. There is a high turn over rate for street outreach workers and offering the course more often would meet the training needs for new employees. In addition, several other states have requested to attend the training as have Ryan White CARE Act funded case finders.

- Complete the implementation of a statewide outcome based evaluation system.

Status: At this time, the statewide outcome based evaluation system is operational. A few adjustments will be made in accordance to the program indicators in the new HIV prevention program announcement. SERL has developed tools to collect information from VDH contractors. This information is submitted to VDH and SERL through the annual and quarterly evaluation forms. The next phase of the project will move towards collecting client level data and electronic data submission.

Population Goals

Racial/Ethnic Minorities

- Reduce AIDS and HIV case rates among African Americans and Hispanics

Status: When the 2000 plan was written, 1999 data showed a combined HIV/AIDS rate among Blacks in Virginia of 68.3 per 100,000. This decreased to 63.5 per 100,000 in 2002. While still substantially higher than the rate among whites (8.8 per 100,000), this indicates movement in the right direction with significant challenges remaining. The 1999 HIV/AIDS case rate among Hispanics was 14.6 per 100,000. This has increased steadily and was 31.9 per 100,000 in 2002. Previously, cases of HIV among the Latino population in Virginia have been lower than the national average. The disturbing trend in case rates for this population indicates an urgent need to increase prevention resources.

Men Who Have Sex with Men

- Increase capacity for provision of effective services for MSM, especially MSM of color

Status: Six agencies are funded by the Division to provide services under the Men who have Sex with Men grants program. Funding for this population has increased from 10% of prevention funds in 1998 to 31% of prevention funds in 2002. Training on the Mpowerment model was provided at the five-day comprehensive training in 2002. Funds targeting MSM of color increased from $95,000 in 1998 to $204, 000 in 2000 to $539,000 in 2002. This represents a 55% increase from 1998 and a 24% increase since the 2000 plan was written. Additionally, contractors also target this population.

Women

- Increase provision of risk assessment and risk reduction skills among women

Status: The need for more scientifically effective interventions has moved previous programming of presentations and lectures to programs that include multiple sessions and skills building activities. Contractors must also conduct risk assessments as part of their evaluation process. The HCPC created standards for Health Education Risk Reduction programs to follow. With the changes in prioritized populations, women are now a sub-category under the heterosexual population to encompass a wider variety of needs.

Injecting Drug Users

- Reduce barriers to access to needles and syringes.

Status: Addressing the needs and goals for injecting drug users has been difficult due to the legal ramifications of using illegal drugs. Virginia law currently requires that only pharmacists may supply needles with a prescription. Reaching this goal would require changing current legislation. Continuing federal prohibition of needle exchange continues to be a barrier. Even if state-level laws and opposition were removed, implementation would be unlikely without the availability of federal funds.

- Increase provision of harm reduction strategies

Status: This goal has been partially addressed through the implementation of the four-day street outreach training that is offered annually by the Division. An evaluation study of street outreach was also conducted. Street outreach specialists who participated in this study received an intense training on implementing the stages of change model for street outreach and incorporation of harm reduction strategies.

Youth

- Provide parent education and resources regarding HIV, STDs, human sexuality and communication skills.

Status: This goal has been difficult to achieve without stronger support and collaboration from the Department of Education. However, the Division has offered training on *Breaking the Silence* and *Keeping it Real. Breaking the Silence* is a faith-based curricula designed for adults working with youth that encourages communication between adults and youth regarding sex and sexuality. *Keeping it Real*, another faith-based curriculum for youth, is designed to promote health decision making regarding sex and sexuality. The faith initiative contractors have implemented these curricula.

- Improve access to comprehensive HIV, STD, substance abuse and human sexuality education for youth.

Status: As stated in the previous goal, without support from and collaboration with the Department of Education and other agencies, there are major roadblocks to providing services and programs for youth.

Incarcerated

- Create linkages between prevention and care for discharge planning.

Status: The major accomplishment is the development and implementation of the Seamless transition program for HIV positive inmates who are returning to the community. Each inmate receives a 30-day supply of medication and an appointment for medical care prior to release. ADAP applications are also completed.

- Increase provision of pre-release prevention programs

Status: Although, there are many contractors who have succeeded in providing programs to incarcerated populations, support from the Department of Corrections varies across the state. Sometimes the support from one facility will vary depending on the agency providing the program. The Division provides release packets for inmates returning to the community through the parole and probation system. In addition, a few contractors are able to conduct HIV testing within the correctional facility. To date, of the prison packet response cards that have been returned, 97% of the recipients have agreed that the information received was easy to understand and useful. Approximately 20% indicated they had contacted a referral source and an additional 7% said they planned to do so when released.

Persons with HIV/AIDS

- Increase provision of primary prevention services to HIV infected persons.

Status: The Division currently funds six agencies under the Prevention for Positives grant program. One region does not have a program due to lack of sufficient funds. However, since 1998, funds targeting PWHA's increased from 3% of the prevention budget to 17%. Additional contractors are also targeting this population.

Short Term Goals

Programmatic Goals

- Provide prevention case management services in all areas of the state for high-risk negatives and HIV infected persons in order to reduce HIV transmission.

Status: There are six agencies funded under the Prevention for Positives grant in four out of the five health regions. Funding is not currently available to expand services to the fifth health region. When the 2000 Comprehensive Plan was developed, however PCM services were being funded in only one site.

- Ensure service providers have adequate training related to transgender/transsexual populations.

Status: Currently, training is provided as a workshop during the five-day educators training. In 2003, members of the HCPC and the transgender community formed the Transgender Taskforce to further address this goal. The Taskforce will guide the development of training activities, focus groups and a needs assessment study of the transgender population in Virginia.

- Continue the identification of at-risk sub-populations within target populations in order to develop appropriate interventions.

Status: In 2001, during year one of the new community planning process, the HCPC identified and defined at-risk sub-populations within the target populations. Further information can be found in section two of this document entitled "Target Populations".

Populations Goals

Racial/Ethnic Minorities

- Decrease barriers to service access.

Status: Decreasing barriers covers a wide variety of issues. Contractors are providing OraSure testing through street outreach, which began in 2001. This resulted in a increase in the number and percentage of African Americans who receive HIV testing. Pamphlets are free of charge from VDH and many of the English versions are available in Spanish as well. The Sexually Transmitted Diseases brochure has been translated into Amharic, Korean, Urdu, and Arabic; the HIV Antibody Testing is available in Amharic, Arabic, Korean, Russian, and Urdu translations; and Shooting Up and HIV is available in Russian as well. Based on recommendations for more scientifically support programs, contractors are required to provide interventions with evidence of effectiveness.

- Increase effectiveness of interventions targeted to racial and ethnic minorities.

Status: Outcome evaluation and the taxonomy of interventions changed the face of funded interventions. There are fewer presentations and lectures provided by agencies and an increase

in group level, individual level, and street outreach interventions including some from the CDC *Compendium of Effective Interventions*.

Men Who Have Sex with Men

- Increase capacity for provision of effective services for MSM, especially MSM of color

Status: The Division currently funds six community-based organizations to provide services to men who have sex with men under the MSM grant program. Funds available specifically for MSM services have increased 84% since this goal was written in 2000. In addition, training for the Mpowerment model is provided at the five-day comprehensive training.

- Increase HIV prevention provided through key opinion leaders in specialized sub-populations of MSM.

Status: This goal has been difficult to attain. Some contractors are able to utilize key opinion leaders. However, this is an area that needs continued focus.

Women

- Increase prevention services to women that recognizes the inclusion of primary sexual partners in service delivery (i.e., prevention targeted to heterosexual men)

Status: Increasing prevention services to women, including prevention targeted to heterosexual men, was accomplished through prioritization of populations in 2001. The target population of women became a sub-category of the heterosexual target population. In 2002, more heterosexual men were provided with HIV prevention services than in 2001.

Injecting Drug Users

- Ensure provision of risk assessment and risk reduction for sex partners of injecting drug users.

Status: Injecting drug users are a focus of the annual street outreach training provided by VDH. Street outreach providers are trained to use the stages of change model during this training. Risk assessments are an integral part of the stages of change model, steering the direction of the staging process. In addition, OraSure contractors conduct oral testing in street based settings for partners of IDUs.

- Improve referral linkages to treatment for IDU.

Status: This goal has been difficult to achieve. There is still a need to improve collaboration with DMHMRSAS about the SAPT Block grants.

- Improve collaboration between HIV prevention service providers and drug treatment providers.

Status: Currently, this goal is still at the starting point. HIV prevention service providers and drug treatment providers either do not see the necessity of working towards a common goal or have no desire to work together, or feel overwhelmed by taking on another issue. Several cross-program work groups and trainings have been organized but these efforts have not been sustained. Competing priorities on staff time is one of the main issues that seem to interfere with this goal. DMHRSAS does have an active member on the HCPC however, and this issue will receive greater attention as the results of the outcome study are discussed.

Youth

- Provide HIV prevention services in environment that are acceptable and accessible to youth.

Status: Many contractors have succeeded in providing HIV prevention services in environments that are acceptable and accessible to youth. However, when examining the information provided by the youth roundtables on youth needs, there are still issues about transportation, safe places, and lack of information provided.

- Increase provision of near-peer interventions for youth.

Status: Current research shows that adult led programs are no more or less effective than peer-led programs for youth. The number of peer-led interventions has increased for youth. However, many of the peer-led programs also have an adult to guide the programming.

- Conduct needs assessment activities to determine effective messages and approaches for youth.

Status: Needs assessment activities have not been conducted for youth. The Virginia Department of Health Office of Family Health Services offered to take the lead on implementing the Youth Risk Behavior Survey in Virginia with funding and support from the American Cancer Society and the Division of HIV/STD; however, the Department of Education declined to participate. Some individual school districts implement the survey; however, the lack of statewide data makes the measurement of progress on delay of intercourse, use of condoms, number of sex partners and drug use limited. This is a source of frustration to the HCPC as this data is greatly needed for priority setting and risk assessment activities.

Incarcerated

- Increase prevention services inclusive of HIV, STDs, TB, substance abuse and viral hepatitis to incarcerated men and women.

Status: Contractors who offer services in correctional facilities routinely provide information about HIV, STDs, TB, substance abuse and viral hepatitis. VDH specifies in its RFPs that contractors provide this information to the clients served under the grant program. Up to date information on these topics is included in the agenda for the annual street outreach training and other trainings that VDH sponsors. In addition, information about HIV, STDs, TB, substance abuse and viral hepatitis is included in the prison packets distributed to incarcerated and paroled individuals.

- Increase access to HIV testing.

Status: Some VDH contractors provide OraSure testing in local jails that allow testing by an outside organization. Although HIV testing in correctional facilities is not entirely discouraged, testing is not strongly encouraged. This is due to the fact that the Department of Corrections does not have adequate resources to support the medical costs of HIV positive inmates. There is also a difference between testing in jails versus prisons. Individuals in jail tend to be incarcerated on a short-term basis, therefore testing is more easily accessible and facilities do not have to address treatment costs. Whereas, prison incarceration times can amount to many years, thus the prison system would face huge costs in caring for individuals that tested HIV positive. On a positive note, the Department of Juvenile Justice (DJJ) conducts health screenings on youth entering the juvenile justice system, including testing for chlamydia, syphilis, and gonorrhea. Based on the screening, youth are offered HIV testing, especially those who have a history of participating in risky behaviors. In addition, DJJ vaccinates youth for Hepatitis B if not previously vaccinated and screens for Hepatitis C based on history and medical presentation.

Persons with HIV/AIDS

- Provide primary prevention services to people with HIV who continue to participate in high-risk behaviors.

Status: VDH funds six community based organizations to provide services under the Prevention for Positives Grant. PCM, group level interventions and support groups are provided. VDH developed the *Positive Living* manual, which includes information on primary and secondary prevention for persons with HIV. The manual has also been translated into Spanish. Several thousand copies have been distributed.

- Provide primary prevention and support services to partners of HIV infected persons.

Status: This is an ongoing goal. Providing services to partners of HIV infected persons is dependent upon HIV positive persons returning for test results and providing partner contact information for notification. In 2002, there were 79,084 individuals tested for HIV. Out of that total, 453 tested positive (0.6% positivity rate) and 265 (58.5%) received post-test counseling.

- Provide resources and secondary prevention services to persons with HIV.

Status: In 2000, the Division of HIV/STD produced a *Positive Living* manual with an accompanying tracker. The manual features medical, psychosocial, legal, nutrition, risk reduction and other primary and secondary prevention information for people living with HIV. The tracker includes areas for recording CD4 cell counts, viral load, symptoms, medications and questions for the health care provider. The manuals are distributed through ASOs and CBOs, health districts, health care providers and medical centers. In April 2002, the Division issued a Spanish language version of the *Positive Living* manual that is being distributed across the state.

New Goals for 2003

After reflecting on the status of goals from the 2000 Comprehensive Plan, the HCPC planned to develop new goals for 2003. However, the Committee postponed this activity given that a new community planning guidance was pending and the Advancing HIV Prevention Initiative had just been released. New goals will be developed after the HCPC has received training on the new community planning guidance. A retreat for the Committee is scheduled for October 2003 to prepare for the 2004 community planning year and to address the changes in the community planning guidance. The Committee will develop goals with consideration to the changes in community planning and prevention.

IX: Linkages

This section provides background information regarding activities undertaken on the part of the Virginia Department of Health (VDH) and its partners in the provision of primary and secondary HIV prevention. Linkages between primary and secondary prevention are highlighted and the relationship between the interventions proposed in the Comprehensive Plan and the prevention of the transmission and acquisition and progression of HIV infection are described.

Primary Prevention

The complexities of HIV disease continue to redefine levels of and responsibilities for prevention. Primary prevention is any intervention designed to stop the further transmission of HIV infection. Traditionally, ASOs, CBOs, and local health districts have carried out a wide variety of primary prevention services including counseling, testing, referral and partner counseling and referral; public information campaigns; presentations and health fairs; street outreach; PCM, individual, group and community-level interventions.

In the past few years, it has been evident that these interventions must have an increased intensity and focus to bring about an interruption in HIV transmission. This requires that prevention providers conduct interventions that focus on not only increasing awareness and knowledge but also effect lasting behavioral changes. Grounded in scientific theory and research, interventions must incorporate a personalized assessment of risk, skills-building in risk reduction and partner negotiation, and support mechanisms. Also evident is the need to make risk reduction approaches flexible for the individual's and community's culture and circumstances and incorporate HIV/STD issues within the context of the client's personal relationships. These tasks can rarely be accomplished with a one-time encounter with clients and most often requires an ongoing relationship with the individual at risk. Through the development of the taxonomy of interventions including the delineation of levels of street outreach, recommendations for incorporating behavioral science, theory and research into the RFP process and prioritization of interventions with a more intensive focus, the HCPC has responded to the need for a strengthened core of primary prevention services.

As the level of accountability increases for providing more intensive interventions and assessing the effectiveness of interventions through outcome-based evaluations, providers need better preparation for conducting primary prevention services. Equally, as treatment for HIV improves and becomes more complex, community-based service providers will need to play a larger role in ensuring that HIV-infected clients are both identified and assisted with obtaining services and educated about strategies to prevent disease progression.

Secondary Prevention

Secondary prevention is any intervention that prevents or delays the onset of illness in persons infected with HIV. Secondary prevention has traditionally been thought of as "care," but consists of a range of services that enhance the lives of HIV-infected consumers, spanning the traditional boundaries between prevention education and care. It may include case management and crisis intervention, support services, early intervention/primary care services, TB testing,

vaccination STD prevention, treatment, family planning services, case finding, mental health services, nutrition education, adequate housing, education and training surrounding medication adherence, stress-reduction etc. The goal of secondary prevention, to limit disease and disability among those already infected, must be accomplished both through provision of both education and health care services and ideally must include active participation, involvement and choices made by the client.

While the structural differentiation between levels of prevention continues, the current trend in client services is toward offering primary and secondary prevention to HIV-infected clients and their partners and families, simultaneously. This places greater importance on adequately assessing clients needs to avoid gaps and duplication of services, especially when there are different federal funding sources: the CDC, for primary prevention for both infected and uninfected individuals and secondary prevention (excluding medical care); and the Health Resources and Services Administration (HRSA), for primary prevention for HIV-infected persons only, secondary prevention and health care services. Ensuring that both primary and secondary prevention are comprehensive and clearly defined is a major task in prevention planning.

Only in the past few years has emphasis been placed on reducing the spread of HIV by working with people living with HIV. The HCPC designated people with HIV as the number one priority target population for primary prevention services in 2001. Resources directed towards preventing further transmission of HIV and prevention of the acquisition of STDs and drug resistant strains of HIV can be beneficial and cost effective approaches for accomplishing both primary and secondary prevention.

CDC estimates that as many as 25% of the U.S. population is unaware of their serostatus. Until now, prevention efforts have focused on persons at risk for becoming infected with HIV through programs aimed at reducing sexual and drug-using risk behavior. Although HIV-prevention programs can be effective, CDC has launched a new initiative aimed at advancing HIV prevention. This will be done through making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside of medical settings, preventing new infections by working with persons diagnosed with HIV and their partners, and decreasing perinatal transmission. Through the Advancing HIV Prevention initiative, every HIV-infected person should have the opportunity to be tested and receive access to medical care and to prevention services needed to prevent HIV transmission.

Virginia Department of Health Activities

The Virginia Department of Health, Division of HIV/STD has primary responsibility for overseeing HIV primary and secondary prevention services for Virginia. Four collaborative work units operate under the umbrella of the Division of HIV/STD: Field Services, Statistics and Data Management, Community Services and Health Care Services. Unit responsibilities follow:

1. **Field Services**: Responsible for confidential HIV/STD counseling, testing, referral, partner counseling and referral services (CTRPCRS), anonymous HIV testing, STD treatment,

HIV/STD surveillance, case reporting, validation studies, technical assistance, consultation, training and quality assurance for local health districts, and special programs for syphilis elimination and chlamydia prevention.

2. **Statistics and Data Management:** Responsible for generating reports, data requests, research activities, enhanced gonorrhea surveillance activities (via OASIS grant), statistical analyses, Geographic Information Systems, database maintenance and integrity, computer programming and computer technical assistance/maintenance. Data entry activities include morbidity reporting, field and interview activity reporting, female gonorrhea and chlamydia screening, hepatitis C, and HIV-1 counseling and testing.

3. **Community Services:** Responsible for HIV/STD prevention activities including: contracting with CBOs for provision of interventions to high-risk populations; the HIV community planning process; public information including provision of a toll-free HIV/STD hotline; and training and technical assistance on HIV/STD, substance abuse and capacity building issues for CBOs and health districts.

4. **Health Care Services:** Responsible for managing Ryan White Title II services, coordinating with Title I and III recipients, managing the AIDS Drug Assistance Program, contracting for early intervention services and health care provider education, and provision of technical assistance and training for standards of care, case management, managed care and continuity of care for CBOs, health districts and private providers.

Linkages Between STD and HIV

HIV/AIDS and STD services have been integrated at the administrative/central office level since 1984 and the local/ field office level since 1986. The Bureau of STD Control was then renamed the Bureau of STD/AIDS. Funding for CBO level prevention programs began in 1986 and management of AIDS medication dollars (for AZT) followed in 1987. Comprehensive care services followed in 1991 with receipt of Ryan White Title II CARE Act funding. In 1996, VDH completed a re-organization, and the Bureau of STD/AIDS was elevated to a Division. One significant outcome was that district and regional supervisory levels for counselors were eliminated. The health counselors became responsible for STD and HIV prevention activities and health counselor supervision was transferred to the health district level. Finally in 1999, central office activities were reorganized into the current structure described above. The designation of Division of HIV/STD was selected to better reflect program and funding priorities.

Services are provided to prevent and control transmission of STDs and their complications through counseling, testing, referral and partner counseling and referral services. STD prevention activities are funded through federal grants and state general funds. The program supports public and private health care provider education, female gonorrhea and chlamydia screening, syphilis elimination activities, testing for congenital syphilis, treatment, surveillance, community-based training and collaboration, and evaluation and design of prevention efforts and strategies. District public health clinics provide integrated STD and HIV services. The Division of HIV/STD supports HIV CTRPCRS in all local health departments.

The integrated program facilitates collaboration by sharing resources and knowledge, and eliminating duplication of services. Surveillance staff collaborates to promote HIV, AIDS, and STD reporting and to define high-risk populations and help target prevention interventions. Patients identified with early syphilis are routinely offered HIV CTRPCRS and a modified congenital syphilis tracking form is used to actively follow HIV+ pregnant women for pediatric surveillance.

The Division operates a combined HIV/STD/Viral Hepatitis Hotline with approximately 20% of inquiries related to STDs or hepatitis. All HIV prevention contractors are required to incorporate STD education into their programs. STD education is included in the Division's five-day comprehensive HIV educator course and its four-day street outreach training.

In 1999, Virginia received funds for Syphilis Elimination activities to focus on the high morbidity areas of Danville, Norfolk and Richmond. Clinical and community-based activities have integrated HIV prevention and testing along with enhanced syphilis testing and PCRS. A Virginia Epidemiology Response Team (VERT) responds to outbreaks of STDs in localities by supporting local health department efforts. VERT has collaborated with AIDS service organizations to conduct outreach and offer blood testing for HIV and syphilis as well as urine screening for gonorrhea and Chlamydia. In the past, testing offered for public information events such as Black HIV/AIDS Awareness Day and National HIV Testing Day was limited to HIV only. Beginning in 2002, the Division has used these opportunities to offer both STD and HIV testing for participants.

In summer 2002, Field Services staff and Community Services staff began collaborating to address the increase in syphilis among gay men in Northern Virginia. Approximately 50% of the cases were occurring among HIV-infected men. Presentations were developed and conducted for the Northern Region HIV Care Consortium, local health districts, the Whitman Walker Clinic, the Arlington Gay and Lesbian Alliance, the Alexandria Health Department, and the Northern AIDS Educators Coalition. Letters and syphilis educational materials were sent to AIDS service organizations to request assistance in increasing focus on syphilis among MSM populations. Outreach/referral cards with a combined HIV/Syphilis message were developed and distributed throughout the region. A combined HIV/Syphilis poster addressing people who find their sex partners through the internet has also been developed. As the syphilis outbreak has been spreading to other areas of Virginia, HIV and STD staff are continuing to collaborate on awareness, prevention and treatment efforts. Local health district staff and VERT have been instrumental in encouraging communication and activities across jurisdiction lines into Washington, D.C. and Baltimore.

STD Subcommittee

In 1996, the HCPC included the STD prevention program in its community planning process. An STD subcommittee was developed to bring community and professional input to the STD Program. Subcommittee representatives comprise prevention and health care professionals, persons at risk for STDs and agencies that work with at-risk populations. The Committee provides feedback on VDH initiatives and grant applications and assists in the development of

provider materials. Community coalition representatives from the Danville and Norfolk Syphilis Elimination Initiatives serve as STD subcommittee and HCPC members.

Counseling, Testing, Referral and Partner Counseling and Referral Services

The HCPC supports CTRPCRS for populations at-risk for HIV. Counseling and testing services help individuals personalize their risk, develop a risk reduction plan and learn their HIV status. For clients who test positive, CTRPCRS links these individuals to secondary prevention services, early intervention and provides services to partners who may be unaware of their risks.

In 1986, Virginia initiated confidential HIV prevention counseling and testing, and referral services in local health department STD clinics. In 1987, these services were expanded to include tuberculosis and women's health clinics. Name reporting for HIV infection was initiated in 1989. Currently, confidential testing is available in all 35 health districts and includes other health department clinics serving persons with risk behaviors for acquiring HIV. In addition testing is provided through designated CBOs. The additional approved sites include the Fan Free Clinic in Richmond and two residential drug treatment programs, Turning Point in Petersburg and Green Street in Portsmouth.

Patients are counseled by public health nurses and health counselors to initiate behavior changes that prevent the transmission or acquisition of HIV. Infected individuals are referred for prompt medical care, preventive, psychosocial, and other needed services. HIV-infected persons are encouraged to refer all sex and needle-sharing partners for counseling and testing

Anonymous counseling and testing services are available through 20 sites geographically located around the state. Originally, four anonymous test sites were federally funded in 1985: Fairfax, Richmond, Roanoke and Virginia Beach. When HIV became a reportable disease in 1989, the state appropriated funds for sixteen additional sites to make anonymous testing more accessible. The sites were distributed so that each of the five health planning regions of the state have four sites. The following sites were added: Alexandria, Arlington, Charlottesville, Fredericksburg, Halifax, Hampton, Harrisonburg, Henry-Martinsville, Montgomery, Norfolk, Petersburg, Portsmouth, Prince William, Richmond, Washington/Wythe, and Winchester. All but three sites (MCV and Crossover in Richmond and Norfolk Community Hospital) are located within local health departments.

Anonymous testing sites are operated by special staff at times other than normal business hours to maintain the confidentiality and anonymity of clients. Persons tested are counseled to initiate behavior changes that prevent the transmission or acquisition of HIV. Infected individuals are referred for medical care and for preventive, psychosocial and other needed services.

OraSure (Oral Mucosal Transudate) Testing

In 2000, the Division of HIV/STD began oral HIV testing through nine pilot sites including ASOs, CBOs and health districts. The testing was conducted only in non-invasive settings such as street outreach venues, mobile vans, bars, home health parties, TB clinic and

walk-in pregnancy clinics. Pilot site results showed that OraSure testing increased the percentage of MSM, IDU, men and African Americans being testing. Seropositivity was higher than in clinic settings and post-test counseling rates were comparable to those in anonymous test sites. Because OraSure testing costs are three times higher than traditional serum testing, it was not found to be cost effective for use with low-risk populations or in walk-in pregnancy clinics. Based on the results of the pilot, VDH awarded eight contracts in November 2001 for OraSure testing focusing on MSM, IDU, MSM/IDU and sex partners of these populations. Sites are permitted to conduct 15% of testing for other high-risk individuals they may encounter during outreach. Results from the first full year of testing (2002) showed a seropositivity rate of 1.4% compared to 0.5% in other confidential settings and a post-test counseling return rate of 58.7%. One-third of patients had not been previously tested.

Testing in Substance Abuse Treatment Settings

Through a federal Substance Abuse Prevention and Treatment (SAPT) HIV Early Intervention Block Grant, the Department of Mental Health, Mental Retardation and Substance Abuse Services funds 22 local substance abuse program within the Community Services Boards (CSBs) system through out the state to provide staff, subcontract out or augment resources to fulfill the HIV SAPT Block Grant requirement to provide appropriate pre/post test counseling, testing. This includes tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system. Funding is also provided for preventing and treating conditions arising from the disease. In addition, these funds can be used by the CSBs to test and screen for TB and Hepatitis.

Referral

Clients who test HIV positive in anonymous and confidential counseling and testing sites are provided referral information for TB testing, medical care, psychosocial support and other needed services. Many of the anonymous and confidential sites are located within facilities that receive funds for early intervention services that make medical care and other needed services convenient and accessible to clients. The Division of HIV/STD maintains and distributes a resource and referral list to facilitate services. Forty-five percent of Ryan White Title II providers also offer HIV testing services enabling a client-friendly transition into services.

TB Testing

Tuberculin skin tests are offered to all persons diagnosed with HIV and AIDS. Health Counselors are required to document the results of TB skin testing before submitting HIV and AIDS reported cases. Individuals with positive TB skin tests are provided prophylaxis treatment. Direct observational therapy is implemented for individuals that would otherwise not adhere to treatment without supervision.

Partner Counseling and Referral Services (PCRS)

When HIV was not a reportable disease, PCRS were offered within public health settings and were available to private providers upon request. Currently, all newly reported HIV infection cases are offered PCRS. Counseling to identify sexual/needle partner(s) is done face-to-face. Both provider referral and patient referral are used in notifying partners. With provider referral, partners are informed face-to-face of their possible exposure to HIV. Follow-up is initiated on those HIV positive individuals who do not return for their HIV results. In the drug treatment centers, substance abuse counselors obtain partner information for the health department staff who then provide notification services. In anonymous test sites, seropositive clients are encouraged to refer their partners, but health department assistance is available upon request. The goals of PCRS are:

- to notify persons who might otherwise not be aware that they were exposed to HIV;
- to assist those sex and needle sharing partners of HIV-infected persons to arrive at an appropriate decision concerning HIV testing; and
- to provide prevention services and referrals for sex and needle-sharing partners of HIV-infected persons.

HIV/AIDS and STD Surveillance

Surveillance activities under the Field Services and Statistics & Data Management units encourage the ongoing and systematic statewide collection of HIV/AIDS and STD reporting from public and private health care providers and laboratories. The surveillance data are routinely assessed to ensure integrity, and are analyzed for emerging trends or shifts in the epidemic.

This program component functions as the central repository for all reports of HIV and AIDS. The program conducts active and passive surveillance throughout the state to track the spread of HIV/AIDS and STDs, to evaluate the completeness of disease reporting in Virginia, to investigate modes of transmission, and to discover unreported cases. The HIV/AIDS report collection process includes periodic public and private provider site visits, establishing reporting mechanisms such as HIV/AIDS line lists, electronic data transfers, and telephone conversations with providers.

The Central Registry Unit (CRU) is responsible for entering statewide STD morbidity and interview activity and HIV and AIDS interview activity in the Sexually Transmitted Disease Management Information System (STD*MIS). These data are used to generate STD morbidity and STD, HIV and AIDS activity reports. HIV/AIDS program consultants use STD*MIS for collecting historical information on HIV and AIDS patients. This information is used to eliminate field investigation activities (unnecessary patient contact), ascertain missing risk information, and to enhance field investigation outcomes. STD*MIS is also used by consultants to track the status of HIV and AIDS field investigations and to communicate updated medical

information. The CRU also maintains a separate syphilis registry that contains historical morbidity reports used to perform record searches.

In addition to the CRU, the Division of HIV/STD also has a STD Surveillance Coordinator whose activities include ensuring the timeliness and completeness of STD reporting from laboratories and from the field. The coordinator has implemented a laboratory evaluation tool to monitor reporting completeness. The coordinator also evaluates STD and HIV surveillance data to identify and address emerging trends in diseases throughout Virginia. The coordinator works closely with members of the CRU in following up problem cases and identifying and addressing issues at the local and central office levels.

Surveillance data are essential in ensuring that Virginia receives its fair share of federal health care dollars for HIV/AIDS. Periodic comparisons are made between the AIDS Drug Assistance Program (ADAP) database and the HIV/AIDS database to determine the completeness of reporting. Likewise, periodic comparisons are made between the Tuberculosis Control Program database and the HIV/AIDS database to identify co-infected patients and ensure appropriate counseling and early intervention services.

Linkages Between HIV Prevention and Health Care Services

Community Services staff are responsible for HIV prevention, public information, training, capacity building and quality assurance activities. The specific grant programs and funded agencies are described in Chapter IV, Resource Inventory. The most significant change from the previous linkages described in the 2000 Comprehensive Plan is the Primary Prevention for Persons Living with HIV grants program that was established in 2002. Six contractors are providing PCM and other primary prevention services. This program grew out of a pilot prevention case management program funded since 1998 at the recommendation of the HCPC.

Thirty-two percent of Ryan White Title II contractors also receive funding for HIV prevention education through the Division of HIV/STD which helps ensure strong linkages between primary and secondary prevention.

Secondary prevention services offered through funded prevention providers includes: case management, emergency funds, transportation, food banks, complementary therapy study groups, weekly psychosocial support groups for a variety of infected and affected populations, educational series on living with HIV, buddy programs and medication adherence support, nutritional counseling and assistance with obtaining entitlement program services. Isolated clients and clients in rural areas also rely heavily on information disseminated through ASO newsletters.

Through the competitive Request for Proposal (RFP), agencies are required to document linkages with substance abuse treatment facilities and other service providers. The importance of counseling and testing for pregnant women and the benefits of medication to prevent perinatal transmission are also included in the scope of service for programs targeting women.

Resources to link people diagnosed with HIV to early intervention, support and other health care services include the Statewide HIV/AIDS Resource and Referral List, a comprehensive directory organized by health region. This list is distributed to local health districts, ASOs, CBOs, Regional AIDS Resource and Consultation Centers, Ryan White Care Consortia, Community Services Boards, the Department of Corrections and Parole and Probation Offices. The Resource and Referral List is the primary resource guide used by the HIV/STD and Viral Hepatitis Hotline counselors.

Annually, the HIV/STD and Viral Hepatitis hotline receives 10,000 telephone calls and distributes 1.5 million prevention and education brochures, posters and pamphlets. These materials cover a broad range of topics, such as women, youth, substance abuse, HIV antibody testing, sexually transmitted diseases, abstinence, guidelines for school and day care settings, infection control and medication protocols. The hotline often serves as the first contact a person has to either primary prevention or secondary prevention services. The most frequently asked question concerns the availability and location of test sites.

The hotline incorporates a client-centered approach to help callers identify and understand their own risk for possible STD/HIV infection. Most callers obtain the hotline number from the phone book. It is also available on every pamphlet distributed.

In 2000, the Division of HIV/STD produced a *Positive Living* manual with an accompanying tracker. The manual features medical, psychosocial, legal, nutrition, risk reduction and other primary and secondary prevention information for people living with HIV. The tracker includes areas for recording CD4 cell counts, viral load, symptoms, medications and questions for the health care provider. The manuals are being distributed through ASOs and CBOs, health districts, health care providers and medical centers. In April 2002, the Division issued a Spanish language version of the *Positive Living* manual that is being distributed across the state.

Ryan White Care Program

The Ryan White Comprehensive AIDS Resource Emergency Act (CARE) of 1990 (amended and re-authorized in 1996 and 2000) addresses issues of secondary prevention across the spectrum of the HIV continuum. Funding is provided for HIV services for clients with incomes below 300 percent of the Federal poverty guidelines. Services are to improve the quality and availability of care, access to diagnostic tests, access to anti-retrovirals and medications to prevent opportunistic infections, substance abuse treatment, dental treatment, and essential support services. The AIDS Drug Assistance Program (ADAP) that provides anti-retrovirals and medications to combat opportunistic infections currently has more than 60 approved medications on its formulary.

Ryan White is federally administered by the Health Resources and Services Administration (HRSA), which oversees programs under four titles, and Part F of the Ryan White CARE Act. Title I provides grants to disproportionately affected metropolitan areas. Title II provides grants to states and territories. Title III supports outpatient early intervention services, and Title IV provides comprehensive services targeting women, children, youth and families. Part F of the CARE Act provides funds to dental schools and collaborative community

dental providers. The Ryan White CARE Act also funds Special Projects of National Significances (SPNS) to develop innovative models of HIV/AIDS care. The AIDS Education and Training Center (AETC) network of regional and national programs are funded to provide HIV-related education and training.

Coordination Between Titles and Planning Activities

The Division of HIV/STD administers the Title II grant for Virginia including the ADAP, awards to five regional care consortia, and the Minority AIDS Initiative. The Central regional consortia also receive Emerging Cities funds. The Norfolk Eligible Metropolitan Area (EMA) began receiving Title I funds in 1998. This is the only Virginia EMA that is currently eligible for Title I although Northern Virginia and portions of the Northern and Northwest regions receive funds as part of the Washington, D.C. EMA. Title III funding has been awarded to four agencies in Northwest, and three agencies in Southwest. To ensure coordination of activities, the Virginia Department of Health (VDH) staff attends Title II Consortia meetings in each region and has membership on the Title I Planning Council. VDH attends national All Titles meetings every two years that provides an overview of the different services offered by different titles that helps in planning and allocation of funds between titles and conducts the Statewide Coordinated Statement of Need, the coordinated needs assessment process for all Titles.

In 2002, the Community Planner staff person began attending consortia meetings in order to enhance linkages between prevention services, the HCPC and the Ryan White Title II consortia. More than thirty percent of HCPC members also participate as Consortia and/or Council members in their respective areas, helping to ensure communication and coordination.

Ryan White Subcommittee of HIV Community Planning Committee (HCPC)

In 1996, the HCPC established the Ryan White Subcommittee. Representatives from each Regional Consortia participate in Subcommittee meetings along with HCPC members. The Ryan White Subcommittee provides a statewide perspective, utilizing regional and other needs assessments conducted by HIV Care Consortia and other organizations.

The purpose of the Ryan White Subcommittee is to advise VDH on:

1. Assessment of client care needs
2. Development of services to meet those needs, and
3. Evaluation of care outcomes.

The subcommittee also developed a list of objectives:

1. To ensure that Ryan White program interests and the HCPC program interests are mutually reflected in the planning process.
2. To coordinate assessment of prevention needs with assessment of care needs.
3. To utilize the work of the HCPC on identifying populations at increased risk for HIV infection to develop outreach strategies to promote enrollment of people with

HIV infection in programs for care, treatment, and primary and secondary prevention.

4. To coordinate with HCPC on developing outreach activities for women to reduce perinatal HIV transmission rates.
5. To define roles and responsibilities in secondary prevention by focusing on areas where prevention and care intersect, impact of new HIV treatments of HIV prevention, and linkages and referrals between programs.
6. To oversee the development of element 7 of the Comprehensive Prevention Plan.
7. To provide input into the Statewide Coordinated Statement of Need (SCSN).
8. To conduct joint public hearings.
9. To provide input into the Ryan White grant application development and contacting process.
10. To monitor national trends for Ryan White programs.

In 1999 and 2001, joint organizational needs assessments of HIV prevention and care providers were conducted to be used as a part of the determination of unmet needs for the Comprehensive Plan and for Ryan White planning. The Prevention and Care Programs collaborated to conduct a series of public hearings across the state in November of 2001.

Past recommendations from the Ryan White Subcommittee included creating messages to encourage testing and accessing of treatment services among African American men, ensuring that physicians are aware of their responsibility to provide counseling and testing services to pregnant women, and funding PCM programs for HIV infected persons. The subcommittee has also updated case management guidelines and established guidelines for coordination of case management with prevention case management within Ryan White Programs based on previous recommendations. Currently, the subcommittee is making recommendations that the disparities among Titles and regions need to be addressed to respond to equal access issues and the emerging needs that are addressed through Title II and Title IV need to be coordinated, especially in smaller areas.

Statewide Coordinated Statement of Need (SCSN)

As a requirement of HRSA funding, VDH coordinates the SCSN every three years. The SCSN provides an opportunity for consumers, service providers, and representatives from all five Titles of the CARE Act, and public agency representatives to review existing needs assessments and evaluations, identify cross-cutting issues in the state, and develop strategies for filling gaps in services. The SCSN is not intended to duplicate existing planning in local areas, but is a tool to further identify the needs of people living with HIV and AIDS.

The last SCSN meeting was held in October 2000. Some HCPC members served on the advisory committee that assisted in meeting planning and participated in the meeting. The goal of the 2000 SCSN was to have 50% of the participants be consumer representatives. This was achieved with 61% consumer participation. The HCPC used the SCSN meeting to promote the community planning process and received applications from a number of consumer participants. The next SCSN meeting will take place in early Spring 2008.

In 2002, a statewide comprehensive care plan to meet HIV care needs was developed by agencies representing both prevention and care. The plan, including goals and objectives, was submitted to HRSA with the FY 2003 Title II grant. This plan will be revised and/or updated at the next SCSN meeting in October 2003.

HRSA has approved outreach programs that assist HIV-infected person in accessing care. This includes newly diagnosed individuals, as well as those not in care or those who have dropped out of care. With CDC's new initiative emphasizing prevention services, including PCM, for persons living with HIV, further collaboration between prevention and care programs will be a necessary enhancement to programs.

Recommendations to Increase and Support Linkages in the Comprehensive Plan

In 2001, the HCPC designated people living with HIV as the number one priority population for primary prevention services. This creates the opportunity to expand linkages between care and prevention programs and provide a hybrid of services that benefits clients. As integration of care and prevention programs are encouraged, CDC and HRSA need to model collaboration and linkages for funded jurisdictions by establishing common definitions, guidelines, and measurements.

The HCPC proposes that the four work units of the Division have the flexibility to communicate the unit's needs as necessary. This includes open communication within the work units and the ability for staff to exchange information with other units.

VDH also needs to provide stronger partnering between the State and local health departments. This would promote collaboration across the state. The needs of the individual districts must be assessed and addressed accordingly. By enhancing the communication between the State and local health departments, the needs of the communities served will be met.

The disparities among Titles and regions need to be addressed to respond to equal access issues.

Skills training for nurses and health counselors who provide post-test counseled PCRS should be provided to enhance entry into care.

X: Surveillance and Research

The Division of HIV/STD made an early decision to enlist the assistance of an external research organization to meet its data collection needs. The Division contracted with the Survey and Evaluation Research Laboratory (SERL) of Virginia Commonwealth University in 1988 to conduct a series of sample surveys assessing the response of Virginians to the epidemic. Surveys were conducted with healthcare providers, service organizations, the general population, and population groups of particular risk for infection. Since initiation of its AIDS research efforts, the SERL has worked with the Division on projects sponsored by both HRSA and CDC, and is now working closely with the Division to integrate related efforts wherever possible, in order to enhance the efficiency and effectiveness of its research and of Virginia's overall response to HIV/AIDS. Coordinated efforts include client and agency needs assessment, knowledge attitude belief and behavior (KABB) surveys, agency- and client-level data collection, subpopulation tailored studies, development of evaluation systems, and client satisfaction surveys.

In addition to addressing the AIDS epidemic through an early structural and legislative response, Virginia was one of the first states to appropriate its own funds to fight the spread of the epidemic. State general funds were appropriated specifically to educate health care providers and others who responded to the needs of individuals affected by HIV/AIDS, through establishment of Regional AIDS Resource and Consultation Centers (RARCCs). Linkages were established between the RARCCs and the SERL, to facilitate the dissemination of research findings to individuals and organizations mobilizing to fight the epidemic.

Thus, a statewide network was created to respond to the challenges of HIV/AIDS, with an applied social science research partner fully integrated from the beginning. As a result of these intentional efforts, virtually all of the SERL's HIV/AIDS research has directly responded to policy questions presented by Federal and State funding sources and has been fed back into the creation and modification of policies, primarily in the areas of HIV education, prevention and provision of services to those affected by the epidemic to those affected by the epidemic and to the systems developed to meet their needs.

VDH and the SERL forged a relationship that has helped to build an infrastructure that supports effective community planning. From the beginning of the research collaboration between SERL and VDH, both entities recognized the need to involve affected populations and health care providers in the planning process. Consumers and providers were included in research planning, involved with implementation when feasible, and always at the table when study results were discussed and recommendations under development. With the initiation of community planning, a further step was taken to ensure inclusiveness of stakeholders. SERL staff and HCPC representatives formed a "Writing Group" to co-author papers from collaborative studies.

When community planning activities were initiated in 1994, SERL was contracted to serve as a social science partner and technical assistance provider. Since that time, more than two dozen KABB surveys have been administered to provide information about target population needs and behaviors that were necessary to the community planning process. These studies have

used a variety of probability and nonprobablity methods to develop samples and have incorporated quantitative and qualitative data collection approaches. The resulting information has been valuable in identifying barriers to services and capacity building needs of prevention providers. It also provides a source of local data as research conducted in San Francisco or New York is often not germane to apply to Virginia's culture and populations.

The HCPC has used the KABB data extensively in its task of prioritizing populations, needs and interventions for the Comprehensive Plan. Full reports including questionnaires and data tables are distributed for HCPC and VDH use. To make the data more accessible and user friendly, larger reports have been summarized into a series of Research Highlights. More than 1,000 copies of each have been distributed to ASOs, CBOs, health districts, Ryan White Consortia and health care providers. These Research Highlights, which contain recommendations for prevention providers, have been used as an integral part of the planning process:

1. HIV-Related Knowledge, Attitude and Behavior of Virginians: 1995 General Population Survey
2. HIV-Related Knowledge, Attitude and Behavior of Virginians: 1995 Sample of Hispanics (also available in Spanish)
3. HIV-Related Knowledge, Attitude and Behavior of Virginians: 1995 Sample of African Americans
4. Virginia's African-Americans, Hispanics and Whites Differ on Responses to HIV/AIDS
5. A Study of Virginia Clergy Concerning HIV and AIDS
6. Men Who Have Sex with Men Who Differ on Risk for HIV also Differ on a Variety of Other Factors
7. Dramatic Differences between White and Black Men who Have Sex with Men
8. African American Clergy See Need for and Obstacles to HIV Prevention Programming
9. Evaluating Intensive Street Outreach with an At-Risk Population
10. Condom Use Among Men Who Have Sex with Men Varies by Situation
11. Study of Latino MSM shows multiple sex partners, inconsistent condom use
12. African American, Latino, and Caucasian men who have sex with men differ in perceptions and behaviors relevant to HIV/AIDS

Some of the survey results and recommendations have also been distilled into one-sheet (front and back) "Tip Sheets" that have been distributed to front-line HIV prevention workers and others who may be interested in very specific, targeted information that arises from the surveys. In addition to KABB surveys, several of these Research Highlights arose out of other projects.

In 1997, the SERL compiled a briefing paper: African American Women with HIV/AIDS in Virginia: Issues and Needs for Prevention Planning. This report provided background information on the epidemic in African American women as well as a literature review on interventions and a discussion of gender roles and power inequities related to HIV infection. Using this information as a backdrop, HCPC research subcommittee members and SERL staff developed a primary survey of African American women to gather data for prevention planning. The study population consists of African American women between the

ages of 18 and 49 (i.e., adult women spanning the range of child-bearing age) who have never been HIV-tested or are unsure of their serostatus. Random digit dial was used to develop a representative sample from the Central Virginia region, and personal interviews were conducted with eligible participants, using a structured interview format. Results were presented to the HCPC in 2002. Conference presentations have been made, and a research highlight and paper are under development.

Evaluating Intensive Street Outreach in Norfolk and Portsmouth Virginia published in 1998, described preliminary efforts to examine the feasibility of conducting outcome-based evaluation of an intensive street outreach intervention using the trans-theoretical model of behavior change to stage clients and mark their progress. This study highlighted the need for a standardized taxonomy of interventions, enhanced training for prevention providers and outreach specialists and the importance of obtaining full support from the administrative levels of the CBOs. This information was critical in identifying training, technical assistance and evaluation preparation needs for Virginia.

Following the street outreach study, SERL conducted a feasibility study, working with six CBOs to evaluate the readiness of contractors to provide standardized interventions, determine the types and amounts of data that contractors could reasonably collect, assess technical assistance needs and determine the "cost" of conducting evaluation. Participating agencies included rural and urban, small and large, minority and non-minority agencies. The resulting Evaluation Feasibility Study Summary Report highlighted the need for enhanced training and capacity building around the provision of interventions as well as specific challenges and barriers to participant level data collection. This information was incorporated into recommendations by the HCPC to VDH, and incorporated into activities within the HIV Prevention Cooperative Agreement. Results and lessons learned from the street outreach and feasibility studies laid a foundation for a current performance monitoring study of the effectiveness of intensive street outreach specialists to reach and maintain supportive, educational contact with HIV-positive African American males reporting intravenous drug use and not in treatment (see below for more detail).

On behalf of the HCPC, the SERL convened a Black Church Advisory Committee and conducted focus groups and personal interviews with African American faith leaders. A pilot project, the African American Faith Initiative was conducted in the Eastern Health region to develop recommendations and provide guidance to funding HIV prevention education in collaboration with faith communities of color. The African American Faith Initiative Eastern Virginian Pilot Study Summary Report, completed in 1999, was used to develop the RFP for funding faith-based projects that year.

A summary report on Latino Men Who Have Sex with Men was completed in August 2000. Results of this KABB conducted in both English and Spanish with urban Latino MSM, will be compared with the MSM survey of African American and White MSM. At least two Research Highlights will be published from the Latino MSM study and from the comparison of these data sets, with recommendations for HIV prevention. These research highlights are under development; a paper has been peer-reviewed and is undergoing revisions for publication.

Continuing its study of the HIV-related needs of Virginia's Latino population, SERL has implemented a second, two-phase study of Latino factory workers in a rural area of the state. During the first phase of the study, individual level data were captured from Latino men, using pencil-and-paper surveys with an interviewer present to answer questions. During the second phase, key informant interviews were conducted with community leaders in the same area, to develop a realistic picture of the existing service system for Latino workers and to gather informed opinions about service gaps and needs. Although the sampling method and data collection mode were somewhat different from those used on the earlier survey of Latino MSM, core questions were the same across both studies. The earlier study recruited participants from urban environments, while the more recent study used methods considered more effective in rural areas. Preliminary results and a draft of the study report have been presented to the HCPC.

Copies of all referenced documents may be obtained by calling the Virginia HIV/STD/Viral Hepatitis Hotline at (800) 533-4148 (within Virginia only) or the Hotline Office at (804) 371-7455.

Ongoing Research

Two primary research studies are currently underway. The "SOS Outcome Study" assesses the ability of four CBOs in Eastern and Central Virginia to implement a rigorous model of Intensive Street Outreach (meeting standards developed by the HCPC), recruiting and maintaining contact with HIV-positive African American males who report intravenous drug use. The study protocol was approved by the VCU Institutional Review Board (IRB) in September 2002. A total of 84 study participants were enrolled and followed for six months, with data collected at intake, three months and six months. The intervention phase of this study closed at the end of June 2003. Evaluative data was collected through mid-August, including post-hoc interviews with street outreach specialists, agency representatives, and VDH contract monitors, who participated as passive evaluators throughout the study.

HCPC and SERL are initiating a transgender research study in late 2003, to be developed and implemented over a period of two years, with fieldwork to commence fall 2003. A first planning meeting was held in early May, bringing together representatives from affected communities, the HCPC, VDH and SERL to form a taskforce/advisory committee and to develop a needs and purpose statement. Attendees were provided with a packet of previous needs assessments conducted in other parts of the country. A nationally-known transgender researcher has agreed to serve as a consultant to this committee and overall for study implementation.

Statewide Evaluation System

Virginia's Statewide Evaluation System for HIV Community Programs is based on a logic model incorporating common measures for inputs, outputs, outcomes and impact, to support both formative and summative evaluation. Interventions (primary and secondary prevention programs) are quite varied, ranging from one-shot presentations to intensive, ongoing contact with targeted individuals over a sustained period of time.

The Division of HIV/STD and the HCPC have actually been preparing to initiate CDC's evaluation requirements since the initiation of community planning. Results from pilot studies conducted to assess provider readiness and resources were used in determining intervention and technical assistance priorities as well as to implement changes in Request for Proposal requirements for funding community providers. Results from population-based studies have provided valuable information for developing educational strategies, establishing realistic standards, and for suggesting success indicators.

In order to develop a statewide evaluation system, VDH decided it was pertinent for all contractors to have a uniform manner in which they articulate interventions as well as to report on the progress. Therefore, a taxonomy of interventions, based on CDC's taxonomy, was developed with input from both the contractors and the HCPC. Next, standardized intervention worksheets were designed to capture an overview of all interventions that each contractor will implement as well as estimates on target population data such as race/ethnicity, age, gender, risk behaviors targeted and anticipated outcomes. The forms were modified from CDC's evaluation guidance to include target populations and priorities of the HCPC. This information will serve as baseline data for the evaluation system and includes core elements required by CDC. All contractors began submitting intervention plans in 2000.

Contractors have received ongoing training through group meetings, individual technical assistance and phone consultation in both the taxonomy and completion of the intervention worksheets. VDH provides each agency with an evaluation notebook containing all pertinent documents as well as computer disks with files of all required forms. The notebook also contains intervention standards developed by the HCPC. Contractors submit quarterly intervention reports that give an overview of progression toward each intervention. Contractors will continue to submit narrative reports that provide the discussion that gives the context for interpreting the quarterly intervention reports. Participant level risk assessment and staging tools will be added as they are developed. SERL has designed data collection forms for the outcome-based evaluation project with input from VDH and the contractors. SERL will enter and analyze data and prepare a final report for VDH.

Contract monitors provide feedback to each report citing strengths, weaknesses and providing assistance in developing outcome based evaluation measures. A portion of contractors have been conducting outcome-based evaluation with follow-up of client risk and behaviors before, after and three months following interventions. SERL provides at-cost data management and reporting for these efforts, upon request from individual contractors.

Information from the intervention worksheets and quarterly intervention reports are entered into an ACCESS database program at SERL. Reports are generated for each contractor and aggregated at the state level. This information is appropriate for basic process monitoring of interventions. As noted above, more robust process monitoring strategies were used for the SOS Outcome Study. Lessons learned from this study may lead to modifications in current contractor reporting.

The Division of HIV/STD received funding for development and implementation of the Evaluation System in July 2000. Until that time, evaluation activities were supported through

community planning funding that was specifically set aside by the HCPC. With the receipt of these dollars, evaluation activities have accelerated and will continue to do so. With HCPC and VDH involvement, SERL is actively developing a more differentiated evaluation system. As contractors demonstrate competencies in implementing interventions and in collecting and reporting data, the feasibility and relevance of collecting individual-level data are being demonstrated. As standards for interventions are being defined, the evaluation system is being enhanced to capture information robust enough to assess adherence to the standards. For those interventions with standards, and where the agency has demonstrated effective implementation of the intervention, Virginia will implement outcome evaluation studies and participant-level data collection at which time contractors will be provided an ACCESS-based software program in which to enter data. The SOS Outcome Study is our first full-fledged test of contractor and system readiness for implementing this model.

VDH Research Activities

Epidemiologic Studies

The Division of HIV/STD recently received funding via a CDC grant to enhance surveillance activities, specifically as related to gonorrhea. The Outcomes Assessment through Systems of Integrated Surveillance (OASIS) grant focuses largely on a survey of STD clinic attendees at the Richmond City Public Health Department. With a few exceptions, all attendees at the clinic are solicited for participation in the survey. Test results of all participants are linked to the survey responses retrospectively in order to provide cross comparisons of behavioral and social demographics among those infected with various STDs. The HCPC provided input into this survey in order to initiate data collection on the transgender population. A previous OASIS grant focused objectives on TB and HIV registry matching and assessment of STD counseling effectiveness regarding recurrent STD diagnoses. Improving the linkages between STD diagnoses and corresponding behavioral and social demographic data will be useful in determining prevention needs for populations as well as refining prevention messages and intervention content. Preliminary data analyses should become available by the Fall.

The Division of HIV/STD received supplemental HIV surveillance funding at the end of 2002 to enhance the Division's capacity to plan and conduct epidemiologic and program evaluation activities in collaboration and coordination with CDC, and state and local HIV prevention and care planning groups. The activities to be performed include the in-house compilation, writing and publication of Virginia's Epidemiologic Profile. The HCPC uses the Profile to assist with population prioritization and unmet need determination. The Profile Coordinator has become a member of the HCPC and attends all HCPC meetings. The Profile Coordinator is also able to explain surveillance data, statistics and trends to HCPC members. The Profile Coordinator attended a meeting to address these issues at CDC in Spring 2003 and has presented data to program managers and local community groups (ASOs, CBOs, etc.).

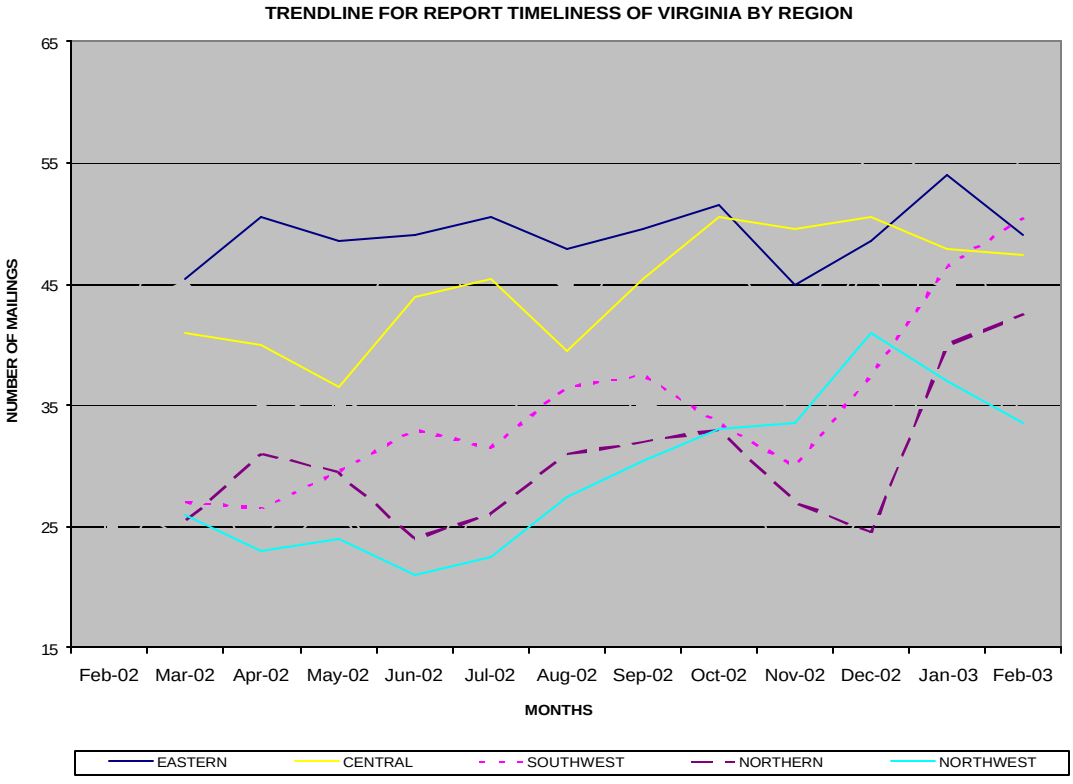
Efforts to Enhance Surveillance and Reporting

The Division of HIV/STD has been tracking mailing patterns associated with HIV/AIDS/STD data that is received in the central office for the past four years. In an effort to

enhance this process, the Division was awarded federal dollars to provide monetary reimbursement for all costs associated with mailings via the OASIS grant. Cost reimbursement for the first quarter of the OASIS grant (October – December, 2002) has been analyzed. Of the twenty-nine health districts eligible for cost reimbursements, twenty-one submitted Account Transfer Vouchers (ATVs) to receive reimbursement of mailing costs. The twenty-one ATVs resulted in $8,838.72 reimbursed to the associated health districts. The cost reimbursements for the health districts ranged from $106.92 to $908.82. The cost reimbursements stratified by health regions were as follows: Northwest $2,013.66; Northern $1,461.24; Central $2,655.18; Southwest $1,924.56 and Eastern $2,601.72.

The Division evaluated the reporting timeliness progress over the first five months of the current OASIS grant objective. Overall, there has been a 62% increase in the number of mailings received in the Division between January 2002 and January 2003. A comparison of the month of February for the same time periods resulted in a 49% increase in the number of mailings received. There was an 18% increase during the first quarter of the current OASIS grant cycle (October 2002 to December 2002).

The increase in the number of mailings received in the Division is probably attributable to two primary issues. Firstly, the Division has initiated weekly surveillance activities within the past year. As such, staff requested improvements in reporting timeliness. Secondly, the cost reimbursements associated with this objective raised interest from the field. A 28% increase in the number of mailings has been maintained comparing November 2002 to each of the succeeding three months. This increase is most likely a direct result of cost reimbursements. In short, reimbursing local health departments appears to have aided in increasing the timeliness of receiving mail. However, this increase in mailings will need to be assessed for the next 6 months to ascertain a better understanding of the cost reimbursement impact.



The Division has also become highly involved in geocoding and mapping and is using this technology to enhance its surveillance capacity. Specifically, geocoding software is being used to ensure morbidity is assigned to the appropriate city/county and to provide additional tools for outreach and screening events. The Division uses Geostan™ software for geocoding and ArcView™ for mapping purposes. Geostan™ provides FIPS city/county data for each geocoded address. The Division uses this data and matches against current FIPS city/county data listed in STD*MIS. Corrections are made to ensure accuracy of reported data for each health region, district and locality (city/county) within Virginia. Historically, Virginia's STD morbidity assignments have been problematic given the layout of statewide jurisdictional boundaries. Unlike most states, cities within Virginia are completely independent entities, including those cities completely encompassed by a surrounding county.

The Division's statistical staff retrospectively completed morbidity reassignments for all STDs for CY2002. A total of 2,404 cases were changed within STD*MIS as a direct result of the Geostan™ software. The area most heavily impacted by the corrections to morbidity assignments was the Richmond metropolitan area. In total, morbidity decreased 713 cases in Richmond City, while Chesterfield County and Henrico County increased 220 and 510 cases, respectively. Correcting such morbidity assignments will assist in properly allocating HIV/STD prevention and education resources.

Determining the accuracy and completeness of HIV and AIDS reporting contributes to confidence in the data used for prevention and health care planning. In addition, reporting of cases helps ensure that Virginia receives its fair share of federal allocations for HIV/AIDS

The Division of HIV/STD Surveillance staff has developed the following process objectives for HIV/AIDS surveillance and reporting:

1. The Epidemiology Consultants and the Surveillance Coordinator will have visited 85% of all active sites at least one time and biannual line lists will have been received from 75% of all active sites by the end of the project year.
2. Conduct at least two validation studies per health planning region or a total of ten statewide by the end of the project period.
3. Each Epidemiology Consultant will have facilitated HIV/AIDS reporting with at least one previously under-targeted provider per health planning region by the end of the project period.
4. The Epidemiology Consultants, for the purposes of case gathering and promoting reporting, will have visited 20 passive facilities that provide care to persons infected with HIV/AIDS by the end of the project period.
5. To assess the effectiveness of HIV/AIDS reporting from one special population in which validation studies are not frequently conducted, the Department of Corrections (DOC) Chief Medical Physician will have provided the Surveillance staff with prevalence listing of all HIV patients housed within all 53 Virginia DOC facilities. All unreported morbidity will be appropriately added to the HIV/AIDS Reporting System (HARS) database.

Enhanced Perinatal Surveillance

Preventing perinatal transmission and ensuring that pregnant women and HIV-infected pregnant women receive appropriate care are important goals in combating the HIV epidemic. As described in Chapter IX: Linkages, Virginia has made significant strides in reducing perinatal transmission through consumer and provider education, and implementation of Virginia's law requiring counseling about HIV testing and treatment for pregnant women. There are a number of factors that may contribute to a rise in perinatal transmission in the future, however: an increasing percentage of HIV-infected persons are heterosexual women; people with HIV are living longer; and more HIV-infected women may chose to give birth given the optimistic outlook possible with new HIV medications. For these reasons, it is important to continue to monitor trends in perinatal transmission. A major concern has been the women who are not provided with counseling, testing and medication because they receive no prenatal care.

In a sample of 130 births, many HIV-infected women in Virginia received inadequate prenatal care. From this sample, 9.1% received no prenatal care, 22.7% had 0-4 visits, 30.7% had 5-9 visits, and 33% had 10-14 visits.

ZDV treatment to reduce HIV transmission during pregnancy has proven cost effective, According to 1995 Survey of Child Bearing Women (SCBW), 79 HIV-infected Virginia residents gave birth. If all HIV-positive mothers had received ZDV therapy and the transmission rate dropped to 8.3% (versus 0 mothers receiving ZDV and a 25.5% transmission rate), then an estimated five infants would be HIV-infected versus 20. This difference of approximately 15 is the estimated number of infections avoided. According to research published in 1997, the money saved in lifetime treatment cost is $492,000/child or $7,380,000 for the 1995 birth cohort. Assuming that HIV seroprevalence among pregnant women remains at the 1995 level of .11%, the number of births remain constant, and the average cost of treatment does not rise, then similar cost savings can be anticipated for each annual birth cohort. The cost savings as well as the health benefit to both mother and child are compelling reasons to ensure HIV infected pregnant women are linked to care.

At the end of 1999, the Division of HIV/STD received funds to conduced enhanced perinatal surveillance. A project coordinator was hired in July 2000. Staff will obtain information on longitudinal follow-up of HIV-exposed children to ascertain maternal HIV status before birth, HIV and AIDS incidence, death, maternal and neonatal ZDV use, ZDV efficacy in preventing HIV transmission, and use of other antiretrovirals perinatally. Targeted will be high-risk OB/GYN clinics, pediatric practices and clinics with a high proportion of HIV-exposed children, perinatally-exposed pediatric cases in the Virginia HIV/AIDS Reporting System (HARS) database, and cases found through birth registry matches. Pediatric medical records will be reviewed and registry matches performed to assess potential adverse outcomes of ZDV exposure at 12 sites during the budget period. The information obtain will be essential to determining prevention needs, care protocols and health policies for HIV-infected women and their babies.

XI: Coordination Among Agencies and Organizations

Coordination among Governmental Agencies

The Division of HIV/STD coordinates with the Departments of Education (DOE), Social Services (DSS), Juvenile Justice (DJJ), and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to provide representation on the HCPC. VDH staff serve on the DOE's AIDS materials review panel and provides faith-based education for African American youth and their parents under a Memorandum of Agreement with the DOE. The Division of HIV/STD has provided nursing in-services for DJJ on a variety of topics including viral hepatitis, counseling and partner notification. Division staff also participated in the planning process for a DJJ nursing conference. DJJ has been instrumental in providing information on high-risk youth for the HCPC's planning process and VDH has assisted DSS in updating AIDS guidelines for its employees.

The Department of Medical Assistance Services (DMAS) administers the Virginia's HIV Insurance Premium Assistance Program to assist HIV-infected clients in maintaining private insurance policies. This is cost beneficial to the Commonwealth as it decreases reliance on Medicaid and allows clients a wider choice of health care providers and care. VDH conducts a match between clients receiving services under the AIDS Drug Assistance Program and Medicaid enrollees to identify charges that can be back-billed to Medicaid and ensure sufficient funding for ADAP eligible clients.

The HIV/AIDS surveillance program has long-standing relationships with the Division of Tuberculosis (TB) Control and the Office of Health Statistics. The Division of TB Control regularly shares information on clients reported with TB and HIV and helps coordinate an annual match of the HIV/AIDS and TB databases. The programs also work closely to identify, test, and care for HIV/AIDS patients infected with TB. Co-infected patients are easily provided a variety of services including partner referral. The same information is used to identify and update HIV/AIDS case records. The Office of Health Statistics provides copies of death certificates on a monthly basis that indicate HIV/AIDS or an AIDS indicator disease as a cause of death, and provides access to death information on individual cases as requested.

The DOC is collaborating with VDH on two projects. Packets containing HIV, STD, TB and Viral Hepatitis information are distributed to parolees by DOC parole and probation officers and by AIDS service organizations through local jails. The Health Care Services unit coordinates the Seamless Transition program, a discharge planning system for HIV-infected inmates. The program is designed to help inmates enroll in ADAP and schedule medical appointments prior to their release to ensure a smooth transition of services in the community. As of April 2003, 253 HIV positive inmates were assisted through Seamless Transition.

The Division of HIV/STD holds a seat on the Ryan White Title I Planning Council in the Eastern Region which is administered by the City of Norfolk.

Finally, the Division of HIV/STD collaborates on numerous levels with Virginia Commonwealth University (VCU). VCU's Survey and Evaluation Research Laboratory provides technical assistance and training to the HCPC and the HIV prevention contractors in the areas of research, behavioral science and evaluation. SERL conducts needs assessments, population surveys and other research on behalf of the HCPC and is conducting the required outcome evaluation study for the HIV prevention cooperative agreement. SERL also coordinates evaluation and data collection for the statewide evaluation process that all prevention contractors are required to conduct. The Division of HIV/STD also contracts with the VCU HIV/AIDS Center for the statewide AIDS Resource and Consultation Center that conducts health care provider education including the HIV prevention counseling course series.

Collaboration With and Among Non Governmental Organizations

Formal and informal community coalitions exist across Virginia for the purposes of promoting HIV education and awareness, providing training opportunities for educators, coordinating services and shaping public policy. Current collaborative partnerships include:

- Virginia Organizations Responding to AIDS (VORA) is a coalition of local, regional, and statewide organizations and private citizens responding to the AIDS epidemic. VORA's mission is to advocate for strong Virginia public policy and to provide the public with information on HIV and AIDS. VORA currently has 35 agencies and individuals in its membership and successfully coordinated visits to 75% of Virginia legislators during the General Assembly session in February.
- The Central Virginia HIV Roundtable convenes to plan joint efforts for outreach, National HIV Testing Day, World AIDS Day and National Black HIV/AIDS Awareness Day. Membership includes the Richmond City Health Department and community-based organizations.
- The Minority AIDS Coalition of the Eastern Region includes AIDS service organizations, 10 faith based organizations, and individuals from the African American community. MACER meets monthly to address HIV issues in minority communities.
- The Eastern Virginia Regional AIDS Coalition plans for events such as the Black Church Week of Prayer and World AIDS Day.
- The Portsmouth AIDS/HIV Taskforce provides information to citizens in the city of Portsmouth and has representation from the Portsmouth Health District, the City Manager's Office and all city agencies.
- The Alexandria Commission on AIDS meets bi-monthly to address care and prevention needs and to formulate public policy with the input of Alexandria citizens. Membership includes the Alexandria Health District, people with HIV, the Alexandria Gay and Lesbian Community Association, clergy, physicians, youth, numerous AIDS service organizations and other city commissions.
- Under the sponsorship of the Central Virginia HIV Care Consortium, Crater HIV/AIDS Services and Education meets monthly and brings together individuals and agencies from the Crater Health District to develop and coordinate care and prevention services.
- The Northern HIV Care Consortium sponsors an HIV Prevention Education Committee to provide a support network, promote appreciation for and enhance the skills of individuals

who provide HIV prevention education and outreach. The Committee meets monthly and provides workshops for those who are interested in HIV prevention.

- In the Southwest region (the largest geographic and most rural area of the state) ASOs have formed three coalitions to collaborate around funding for prevention, care and housing. Collaboration is a challenge due to vast driving distances, but a necessity to coordinate limited resources that are scattered across the region.
- The five regional AIDS service organizations funded by VDH have formed a statewide Outreach Coalition that meets quarterly to provide education and support to outreach specialists. The stress and difficulty of outreach work has taken a toll on outreach staff, who need the opportunity to receive ongoing support from their colleagues. Meetings are held in a different region each quarter.
- Organized under the Virginia Commonwealth University HIV/AIDS Center, the Peer Advocates Coalition of Central Virginia provides support and advocacy for persons newly diagnosed or "lost to care". Peer advocacy services include HIV testing and counseling, one-on-one peer counseling, medication adherence education, community mobilization and outreach to "at risk" populations, support groups, assistance in securing entitlement benefits and navigation through complex systems of care.

Many coalitions were formulated, formalized, or strengthened from the creation of Ryan White Title II Care Consortia in the early 1990s, and the Title I Planning Councils in the Northern and Eastern regions. The requirement for localities to collaborate on health care gave impetus for the participating agencies to collaborate on prevention as well. Quarterly statewide meetings for the five Ryan White Title II Consortia lead agencies are also held to address common concerns and conduct planning. Representatives from each of the Consortia serve on the Ryan White subcommittee of the HCPC.

Through the Syphilis Elimination Initiative, community health coalitions were created in Danville, Norfolk and Richmond, the three areas targeted for syphilis elimination. The coalitions have supported health care provider forums, outreach, HIV and syphilis testing and health fairs. The community coalition in Danville recently sponsored advertisements in area movie theaters and has begun to address other community health issues. Representatives from the Danville and Norfolk syphilis elimination coalitions serve as members of the HCPC.

The African American Faith Initiative (AAFI) funding has created linkages between VDH and faith communities. Proposals for funding from religious institutions have been submitted for grants programs other than AAFI and contractors are having greater success in establishing cooperative ventures. VDH and the Black Church Coalition for Reproduction Choice have cosponsored numerous train-the-trainer courses on "Keeping It Real", a faith-based curriculum on human sexuality, sex and HIV for African American youth, and "Breaking the Silence", a human sexuality curriculum for adults.

VDH funds more than 40 organizations, both governmental and non-profit, to provide HIV prevention education in Virginia. In the competitive selection process, offerors are required to demonstrate how they will collaborate with other agencies in their area and ensure non-duplication of services. Letters of agreement from collaborating institutions such as schools, drug treatment centers, jails and prisons, and shelters are required. Quarterly contractor meetings

are held to share information about successful programs, concerns and to provide technical assistance in evaluation and intervention development. The Community Collaboration Grants program requires that local health districts collaborate with CBOs to strengthen linkages, and encourage awareness of and utilization of community services.

Enhanced Communication through Technology

Increased access to computers and the internet has enhanced communication and collaboration among HIV/AIDS service providers. In October 2001, the Division began sending a monthly electronic bulletin to health districts, community-based organizations, HCPC members and other interested persons. The bulletin provides updates on personnel, resources, funding opportunities, training, programmatic issues and resources. In addition, the Division's web page has been expanded. Individuals can download information on Requests for Proposals, see the schedule for HCPC meetings and trainings, download an application for the HCPC, obtain the latest statistical reports and email questions to the hotline staff or the Health Department Co-Chair of the HCPC.

The AIDS/HIV Services Group in Charlottesville has expanded a Northwest regional listserve to the entire state so that AIDS service organizations can exchange information related to HIV prevention and care services. The public relations coordinator for the Division of HIV/STD has started a media specific listserve to assist CBOs in maximizing media in their public information efforts and to exchanges ideas across the state.

Further descriptions of collaborative efforts can be found in Chapter VIII, which describes linkages between primary and secondary prevention.

XII: Technical Assistance Needs Assessment and Plan

Prevention Provider's Technical Assistance Needs

Technical assistance needs of prevention providers were collected through a variety of sources including five regional public hearings and an organization needs assessment, both conducted as part of the planning process in 2001. These activities are described in detail earlier in this plan.

Although the five health regions of Virginia represent a wide variety of areas and the needs of the more rural areas differ from the needs of the metropolitan areas, there are similar needs across the state.

- Capacity Building is needed for CBOs. Many agencies do not have the capacity to compete for funding against the larger CBOs in their area.
- The need to reach incarcerated populations. The emphasis was placed on reaching individuals leaving the correctional system.
- Transportation for clients. Especially in rural areas, but also Northern Virginia.
- Need for involvement of faith institutions and faith-based brochures.
- Need for minority health care providers.

The organizational survey asked respondents about prevention staff training needs in fifteen topic areas. Overall, "strategies for accessing hard-to-reach populations" was perceived as a major need for prevention staff training throughout Virginia. Evaluation methods were also highly rated in almost every region. Those items rated as being a major need by more than 20% of the respondents include:

- Strategies for accessing hard-to-reach populations
- Evaluation methods
- Effective interventions
- Prevention case management
- Theories of behavior change
- Transgender issues
- Substance abuse issues

Through feedback from the Division of HIV/STD contract monitors and examination by HCPC and the SERL funded interventions, the following additional technical assistance needs were identified:

- Strategies for accessing hard-to-reach populations
- Clarify the difference between Prevention Case Management (PCM) and Case Management
- Capacity building and fiscal management
- Training in outcome measures, data collection, and performance indicators.

- How to conduct risk assessments
- Transgender issues and training to provide culturally competent services
- Writing goals and objectives and individual work plans
- HIPAA
- Training for HIV counseling and testing
- Culturally appropriate interventions for target populations
- PCM training
- Strategies and successful intervention for PWAs
- Strategies for working with men of color who have sex with men and the down-low population
- Knowledge of effective interventions for a variety of racial and ethnic minority populations
- Social marketing
- Substance abuse issues

It should be noted that VDH conducted trainings for board development and fiscal management in early 2003. However, some agencies in need of training did not choose to take advantage of the opportunities provided. CBOs have also begun to take a larger role in HIV testing since VDH began funding OraSure contracts in November 2001. With the availability of rapid testing and CDC's new initiative to expand routine testing in medical settings and through community-based organizations, CBOs will require training in testing procedures, confidentiality, informed consent, prevention counseling, and state testing laws and regulations. In addition, as CDC's requirements for evaluation become more complex, community-based contractors will need continuous training to stay current.

The three sources for identifying technical assistance needs (public hearings, organization survey and VDH/HCPC) needs identify similar themes around interventions for target population, evaluation and cultural competency. In the past three years, the Division of HIV/STD has offered a number of training opportunities to address identified technical assistance needs including some of the topics listed above and those identified in the 2000 Comprehensive HIV Prevention Plan.

Training to improve interventions for specific target populations has included:

- A two-day workshop in collaboration with the Black Church Initiative of the National Religious Coalition for Reproductive Choice on the "Keeping it Real" and "Breaking the Silence" for African American youth and adults respectively.

Training focused on refining interventions across populations have included:

- One, three-day workshop, "Core Strategies for Street and Community Outreach" for outreach specialists and their supervisors.
- One, five-day "Comprehensive HIV Health Educator Training" including topics on cultural competency, role of faith institutions in HIV prevention, taking sexual and drug history risk assessments, using the media effectively, working with transgender populations, men on the down-low, understanding African American men and prevention

for positives. Two days were allotted to training in specific HIV prevention and behavioral models such as "Kid Focus", Basic Behavioral Science", MSM Mpowerment Model" and "Prevention Case Management".

- Five, one-day training sessions for community-based organizations providing OraSure testing.
- The Regional AIDS Resource and Consultation Centers provide prevention counseling training: "The Facts", a one day course that includes an HIV medical overview, explanation of the tests, confidentiality and legal issues and "The Approach", a two-day course that includes training on client centered counseling, risk assessment, test decision and provision of test results. The RARCCs also provide a clinical component, "The Experience" that includes observation of the counseling and testing process.

Additional training and technical assistance provided:

- The STD Community Educators workshop for contractors.
- Training sessions on "Records and Reports" for public health nurse supervisors and health counselors conducted in three health regions.
- One, one-day cross training for on "Confidentiality and Legal Issues".
- One "Train the Trainer" session conducted in collaboration with DMHMRSAS for the HIV/STD, TB and Substance Abuse Cross-training.
- Basic Behavioral Science

HCPC Technical Assistance Needs

With new members brought into the planning process each year, there is a continual need for the HCPC to revisit training topics. The HCPC requests training in behavioral science and theory from a national technical assistance provider at least every other year to help prepare for the prioritization of interventions. Needs are also identified informally at HCPC meetings and mini-workshops are often incorporated into the meeting agenda.

New topics identified for technical assistance in 2003 include:

- Training on transgender issues;
- Strengthening the membership of the Research subcommittee by including a strong segment on SERL and its role in community planning including a history of studies that have been conducted;
- Training on the role of theory, especially the Stages of Change model, in HIV prevention. Technical Assistance can be sought through AED and must ensure that the training meets the needs of the HCPC, not just a general overview of theory presentation.
- Technical assistance on developing a stronger needs assessment and gap analysis portion of the Comprehensive Plan.
- Training for the new Community Planning Guidance.

Additional technical assistance is obtained each year at the National Community Planning Leadership Summit for HIV Prevention. VDH supports the attendance of the Co-chairs and two additional members who have not previously attended. Other members also attend

through alternate funding sources. Due to the variety of workshops, the Summit provides an opportunity to gain knowledge and skills in the relevant stages of the HCPC's three-year planning process. All HCPC members may attend the Prevention Counseling courses offered by the RARCCs and receive reimbursement for the course cost.

VDH Technical Assistance Needs

Division of HIV/STD contract monitors have increased the provision of individualized technical assistance to agencies. In addition to feedback and recommendations on progress reports and site visits, staff have provided assistance in rewriting workplans to include measurable objectives. Significant time has also been invested in reviewing the intervention taxonomy and assisting agencies in identifying intervention goals and outcome and completing intervention worksheets.

Although the contract monitors work closely with SERL on outcome evaluation, there should be more involvement with the changes in outcome evaluation and the new indicators. All of the contract monitors would benefit from continuing education.

In order to ensure that health counselors are adequately trained, all health counselors should attend CDC's two-week ISTDI course. The central office should conduct periodic statewide staff meetings and provide continuing education opportunities for health counselors, as well as conducting skills inventories routinely.

Recommendations

VDH should utilize technical assistance, training and quality assurance funds in its federal HIV Prevention Cooperative Agreement to address the unmet needs described in this Chapter. Major themes revolve around:

- Training to identify and provided effective and culturally appropriate interventions for a variety of populations with a heightened focus on transgender and racial and ethnic minorities;
- Ensuring that educators are adequately prepared to conduct interventions including skill development in accessing hard-to-reach populations, risk assessment and sexual history taking, substance abuse and mental health issues;
- Providing ongoing training on outcome evaluation, data collection and performance indicators;
- Training to fully implement CDC's new program announcement and the new HIV initiative.

These issues need to be addressed in the context of preparing providers to consider the unique factors of each target populations culture and circumstance whether those factors are race, ethnicity, gender, incarceration or living with HIV infection. VDH should also ensure that some technical assistance is provided regarding Latino/Hispanic, Asian/Pacific Islander/ and immigrant populations as the majority of prior technical assistance has focused on African Americans.

XIII: Evaluation of the Community Planning Process

The Process

Goal: *Ensure that the Virginia HIV Community Planning Committee operates in accordance with the principles of parity, inclusion and representation and accomplishes the five core objectives of community planning:*

Fostering the openness and participatory nature of the planning process.

Ensuring that the CPG reflects the diversity of the epidemic in Virginia, and that expertise in epidemiology, behavioral science, health planning, and evaluation are included in the process.

Ensuring that priority HIV-prevention needs are determined based on an epidemiologic profile and a needs assessment.

Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

Fostering strong, logical linkages (i.e. connections) between the community planning process, the comprehensive HIV prevention plan, the application for funding and allocation of HIV prevention resources.

Objectives 1: Address membership composition at each meeting of the HCPC and make recommendations for recruitment to ensure a planning group that reflects the epidemic in Virginia.

Accomplishments: The HCPC maintains representation from five health planning regions. These planning regions mirror those used for Ryan White Title II allocations and for epidemiological descriptions and analyses. During 2002, there were 33 members on the HCPC including 28 community members and five appointees from state agencies (Health, Social Services, DMHMRSAS, DJJ, and DOE).

Three youth advisory councils located in the Northern, Central and Eastern health regions were established to provide input from young people. HCPC members staff each of these councils to provide technical assistance and serve as a link to the larger HCPC. One youth advisory council member also sits on the HCPC. Approximately 45 youths between the ages of 14 and 24 participate in the youth council process.

New member recruitment includes targeted mailings to individuals and organizations. The mailings include a cover letter, question and answer format flyer about community planning and an application. Recruitment also takes place at meetings and conferences through a community-planning table and display board. Recruitment is announced through the Division's monthly electronic bulletin. A Community Planning section is accessible on the Division's web page. Application forms can be downloaded from the web. Membership is included as an agenda at each HCPC meeting and members are charged with recruitment to fill gaps in membership

through networking and word of mouth. Newspaper advertising has not proven successful in the past and is not conducted.

The nomination/application process is open at all times. Nominees receive a letter acknowledging receipt of their application and explaining the nomination process. Applications are kept in an open nominee file for two years and considered each time members are nominated (generally twice each year). Applications are reviewed by the Co-Chairs and brought before the entire HCPC with name identifiers removed, and finally, forwarded to VDH for approval and appointment.

Objective 2: Conduct an annual survey of HCPC members to assess PIR and the core objectives applicable to the current year's activities in the three-year planning cycle.

Accomplishments: The Community Planner has conducted annual surveys of the HCPC members. The Virginia HCPC year-end evaluation is adapted from and utilizes questions from the CDC Evaluation Guidance. Areas covered include the general meeting process, understanding of the planning process and concepts, confidentiality and respect between HCPC members, progress on the core objectives, assessment of parity and power sharing between members, and perceptions of the impact of the planning process on HIV prevention in Virginia. The 2002 year-end evaluation is included at the end of this section.

Objective 3: By the end of the three-year planning cycle, assess the annual cost of conducting community planning in Virginia.

Accomplishments: Annual costs for community planning meetings, administration and development of the comprehensive plan average $115,000. This does not include funds expended for research and needs assessment activities including surveys, focus groups and population-based studies that inform the community planning process. Costs for these items are incorporated into a single contract that also includes technical assistance to the HCPC and prevention contractors as well as the required statewide evaluation and data collection system. As the HCPC has been integrally involved in the development of the outcome evaluation system, it is difficult to separate these costs. $229,000 is spent annually on these additional activities.

The Outcome

Goal: *To assess the extent to which community planning has affected HIV prevention service delivery in Virginia in terms of appropriate targeting of populations and geographic areas, intervention quality and effectiveness and efficient use of prevention funds.*

Objective 1: By the end of the three-year planning cycle, compare Counseling and Testing, and Health Education/Risk Reduction funding allocations by race, sex, and risk to HIV/AIDS demographics for Virginia and to HCPC priority population designations.

Accomplishments: VDH has prepared annual budget tables and presented this information to CDC, the HCPC and its contractors. Comparisons with prior year amounts and the Epidemiological Profile are included to document improved targeting of prevention dollars. Since 1998, funds targeting MSM went from 10% to 31% of the prevention budget. Funds targeting people with "other or unknown" risks declined by more than $200,000. Funds targeting people with HIV increased from 3% of the budget to 17% of the budget.

Objective 2: By the end of the three-year planning cycle compare current year budget tables to pre-community planning budget tables and tables from the previous community planning cycle to assess the impact of community planning on targeted prevention funding.

Accomplishments: Please see graph on page 138.

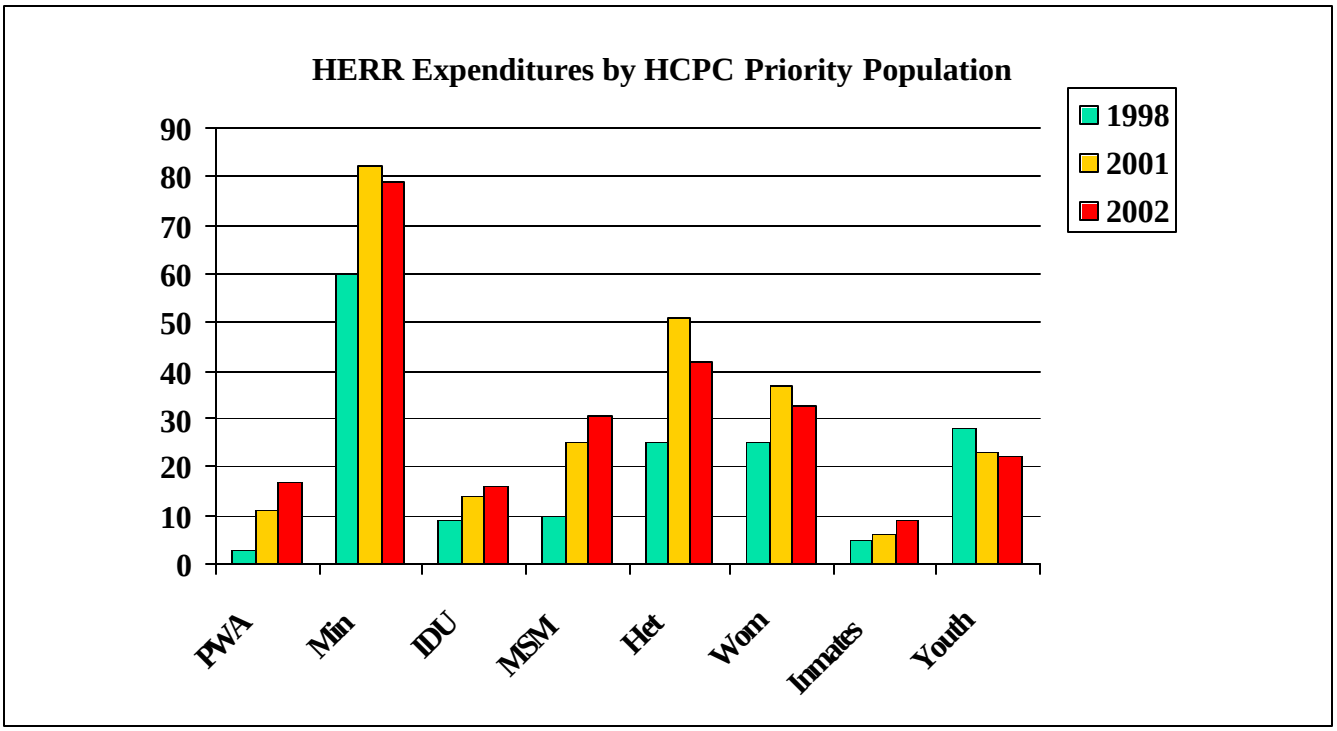
Objective 3: By the end of the three-year planning cycle, compare the number of individuals who are members of priority populations and provided with interventions to the proportion of those populations targeted for services.

Accomplishments: The data collected from the annual intervention worksheets of contractors and cumulative intervention reporting worksheets was used by the HCPC to identify met and unmet needs in HIV prevention in Virginia. The interventions available across Virginia for priority populations were compared to the epidemiogical profile of HIV incidence in Virginia. The conclusions were used to make recommendations for future prevention planning activities.

Objective 4: By the end of the three-year planning cycle, compare the number and types of interventions provided for each population with the intervention priorities established by the HCPC.

2002 Evaluation

The most recent evaluation of HCPC activities was conducted in December 2002. The chart below shows comparisons of funding from 1998 to 2002 for HCPC priority populations. Programmatic evaluation will be revised to follow CDC's new community planning guidance released in 2003.



2002 HCPC Year End Evaluation

Demographic Information

Age	16-19	20-24	25-29	30-49	50+
	0%	4.2%	0%	70.8%	25%

Race	
41.7%	African American
0%	American Indian/Alaskan Native
8.3%	Asian/Pacific Islander
37.5%	White/Caucasian
12.5%	Unknown

Ethnicity	
12.5%	Hispanic or Latino
29.2%	Not Hispanic or Latino
58.3%	Unknown

Gender	Male	Female	Transgender
	54.2%	41.7%	4.2%

Type of organization you represent or are affiliated with:

1	Faith Community
1	Research Center
3	Health department
2	Government organization
12	Community-based organization
0	Member of affected community (not affiliated with organization)
2	Health care provider
1	Academic institution
2	Other: AIDS service organization and private health care center

Type of geographic location in which you live:

Urban Metropolitan Area	Urban Non-Metropolitan Area	Rural
62.5%	12.5%	25%

Does your organization receive HIV prevention funding from the health department?

Yes	No	Not applicable
45.8%	29.2%	25.0%

How many years have you served on the Virginia HIV Community Planning Committee?

20.8%	Less than 1 year	8.3%	Three	8.3%	Six
8.3%	One	8.3%	Four	0.0%	Seven
20.8%	Two	0.0%	Five	12.5%	Eight
				12.5%	No Response

Approximately how many CPG meetings did you attend during the past year? There are eight (8) CPG meetings scheduled during the year.

Eight	Seven	Six	Five	Four
20.8%	33.3%	29.2%	8.3%	8.3%

Including time spent in CPG meetings, how many hours do you spend on all CPG activities per month?

Mean: 13.2 hours Median: 10 hours Mode: 10 hours Range: 0 – 30

Which of the following best describes the influence of CPG members?
(Check the one that most applies)

#	%	1 – 2 years	3 – 5 years	6 – 8 years	
19	79.2%	83.3%	60.0%	85.7%	Members who are health department (HD) staff and members who are not HD staff have equal influence
2	8.3%	8.3%	20.0%	0.0%	Members who are HD staff have more influence
1	4.2%	8.3%	0.0%	0.0%	Members who are not HD staff have more influence
2	8.3%	0.0%	20.0%	14.3%	I don't know

Please rate your agreement with each of the following statements

		#	%	1 – 2	3 – 5	6 - 8
1. Members from organizations that receive health department funds have more influence than other members.	Strongly disagree	12	50.0%	50.0%	40.0%	57.1%
	Somewhat disagree	4	16.7%	16.7%	20.0%	14.3%
	Somewhat agree	5	20.8%	8.3%	40.0%	28.6%
	Strongly agree	3	12.5%	25.0%		
	I don't know.					

		#	%	1 – 2	3 – 5	6 – 8
2. During the past year, the role of the CPG has been very clear to me.	Strongly disagree	1	4.2%			14.3%
	Somewhat disagree					
	Somewhat agree	3	12.5%	25.0%		
	Strongly agree	20	83.3%	75.0%	100%	85.7%
	I don't know.					

		#	%	1 – 2	3 – 5	6 – 8

3. During the past year, my role on the CPG has been very clear to me.	Strongly disagree	2	8.3%			28.6%
	Somewhat disagree					
	Somewhat agree	7	29.2%	41.7%	40.0%	
	Strongly agree	15	62.5%	58.3%	60.0%	71.4%
	I don't know.					
		#	**%**	**1 – 2**	**3 – 5**	**6 – 8**
4. Some group members advocate for hidden agendas more than for the agenda of the CPG.	Strongly disagree	6	25.0%	25.0%	40.0%	14.3%
	Somewhat disagree	7	29.2%	33.3%	40.0%	14.3%
	Somewhat agree	10	41.7%	33.3%	20.0%	71.4%
	Strongly agree	1	4.2%	8.3%		
	I don't know.					
		#	**%**	**1 – 2**	**3 – 5**	**6 – 8**
5. The CPG is culturally sensitive.	Strongly disagree	1	4.2%			14.3%
	Somewhat disagree					
	Somewhat agree	5	20.8%	33.3%		14.3%
	Strongly agree	18	75.0%	66.7%	100%	71.4%
	I don't know.					
		#	**%**	**1 – 2**	**3 – 5**	**6 – 8**
6. The CPG is a well organized group.	Strongly disagree	1	4.2%			14.3%
	Somewhat disagree					
	Somewhat agree	6	25.0%	25.0%	40.0%	14.3%
	Strongly agree	17	70.8%	75.0%	60.0%	71.4%
	I don't know.					

Core Objective 1:

Foster the openness and participatory nature of the planning committee.

Please rate each element on a scale of one to five with one indicating "strongly disagree" and five indicating "strongly agree". If the question does not apply to you please circle "N/A". If you do not know, please circle "DK" for "Don't Know".

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

	All	**1 - 2**	**3 – 5**	**6 - 8**	**N/A**	**DK**
1. Other members respect my opinions, beliefs and values.	4.5	4.6	4.3	4.5		1
2. Technical terms, concepts and acronyms are clearly defined so that all members can understand them.	4.0	3.9	3.8	4.4		
3. If I do not understand a word or concept being used, I feel comfortable asking for information.	4.6	4.6	4.0	4.9	1	
4. CPG members have input into the agenda of each meeting.	4.5	4.3	4.3	4.9		
5. I have an equal voice with others members of the CPG.	4.5	4.7	4.0	4.5		
6. Meetings are set up to encourage participation from all members.	4.5	4.8	4.3	4.3		
7. The meetings are run smoothly/efficiently by the Co-Chairs.	4.5	4.6	4.0	4.5		
8. Input from non-committee members is sought out and included in the planning process.	4.3	4.4	4.0	4.4		1
9. Meeting summaries are well documented and available to non-CPG members.	4.5	4.6	4.3	4.4		2
10. Meetings are open to the public.	4.6	4.7	4.0	4.9		2

Core Objective 2:

Ensure that the CPG reflects the diversity of the epidemic in its jurisdiction and that areas of expertise, as outlined in the guidance are included in the process.

Please rate each element on a scale of one to five with one indicating "strongly disagree" and five indicating "strongly agree". If the question does not apply to you please circle "N/A". If you do not know, please circle "DK" for "Don't Know".

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

	All	1 – 2	3 – 5	6 - 8	N/A	DK
1. The CPG reflects the diversity of the HIV epidemic in Virginia.	4.5	4.6	4.0	4.5		
2. Our CPG include scientific experts, health planners, and governmental and non-governmental service providers.	4.8	4.8	5.0	4.9		
3. When the CPG falls short of being representative, we have developed and implemented a specific action plan to improve representation.	4.3	4.3	3.7	4.5		5
4. CPG members are recognized as members of the specific community or target populations they are representing.	4.4	4.4	4.0	4.8		1
5. Expertise and technical assistance in the areas of behavioral science, epidemiology, health planning and evaluation are available to and used by the CPG.	4.8	4.8	4.5	5.0		
6. The CPG addresses special needs of its members such as transportation, expenses, honoraria, training and development.	4.7	4.7	5.0	4.6		3
7. There is an adequate mix of people infected with and affected by HIV/AIDS on the CPG.	4.8	4.8	4.8	4.6		

Core Objective 3:

Ensure that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment (including community sources of information).

Please rate each element on a scale of one to five with one indicating "strongly disagree" and five indicating "strongly agree". If the question does not apply to you please circle "N/A". If you do not know, please circle "DK" for "Don't Know".

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

	All	1 - 2	3 – 5	6 - 8	N/A	DK
1. The Epidemiologic Profile is presented in a way that is easy to understand.	4.5	4.5	4.5	4.5		1
2. A wide variety of data sources were used to compile the Epidemiologic Profile.	4.6	4.4	4.8	4.8		1
3. The needs assessment is used to determine prevention priorities.	4.6	4.3	5.0	4.9		1
4. The CPG's needs assessment includes an inventory of resources, input from target populations and identification of unmet needs.	4.5	4.4	4.7	4.5		2
5. The needs assessment is useful for decision-making purposes.	4.8	4.6	5.0	4.9		1
6. The plan adequately incorporates data from the needs assessment.	4.7	4.5	4.8	4.8		1

Core Objective 4:

In the prioritization of interventions, ensure that explicit consideration is give to priority needs, outcome effectiveness, cost effectiveness, theory and community norms and values.

Please rate each element on a scale of one to five with one indicating "strongly disagree" and five indicating "strongly agree". If the question does not apply to you please circle "N/A". If you do not know, please circle "DK" for "Don't Know".

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

	All	**1 - 2**	**3 – 5**	**6 - 8**	**N/A**	**DK**
1. Social and behavioral science theories are considered.	4.7	4.6	4.5	4.9		
2. Community norms and values are evaluated when analyzing the priorities of HIV intervention.	4.7	4.7	4.5	4.8		1
3. The HIV interventions were cost effective.	4.4	4.2	4.5	4.4		4
4. CPG members know the effectiveness of intervention.	4.1	3.9	4.3	4.4		2
5. Intervention focused on the needs of the target population.	4.6	4.4	4.8	4.8		

Core Objective 5:

Strive to foster strong, logical linkages between the community planning process, plans, applications for funding, and allocation of CDC HIV prevention resources.

Please rate each element on a scale of one to five with one indicating "strongly disagree" and five indicating "strongly agree". If the question does not apply to you please circle "N/A". If you do not know, please circle "DK" for "Don't Know".

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

	All	1 - 2	3 – 5	6 - 8	N/A	DK
1. CPG members understand the relationship between the funding application to CDC and the Comprehensive Plan.	4.4	4.1	4.5	4.8		2
2. The Virginia Department of Health's (VDH) most recent application reflects the priorities and recommendations set by the CPG.	4.8	4.6	4.8	5.0		2
3. CPG recommendations have changed the types of interventions funded.	4.7	4.7	4.5	4.7		2
4. VDH has redirected funds to meet the needs of priority populations.	4.8	4.8	4.5	4.9		3
5. The Community Planning process has influenced the implementation of more effective interventions.	4.9	4.8	4.8	5.0		1
6. There was adequate time to comment on health department's application for funding before it was submitted to CDC.	4.8	4.8	4.8	4.7		3

General Questions about Community Planning

Please rate each element on a scale of one to five with one indicating "strongly disagree" and five indicating "strongly agree". If the question does not apply to you please circle "N/A". If you do not know, please circle "DK" for "Don't Know".

1	2	3	4	5
Strongly Disagree				**Strongly Agree**

	All	**1 - 2**	**3 – 5**	**6 - 8**	**N/A**	**DK**
1. Committee members who take on assignments or information gathering usually follow through.	4.2	4.3	4.5	3.7		5
2. VDH provides the information, tools and support the CPG needs to accomplish its work.	4.6	4.6	5.0	4.5		5
3. The Survey and Evaluation Research Laboratory is responsive to the CPG's needs and provides information and deliverables in a timely manner.	3.5	3.4	4.5	3.0		5
4. Coordination of prevention and health care services has been improved because of the community planning process.	4.5	4.6	4.8	4.2		6
5. I receive information in enough time to prepare for meetings.	4.7	4.6	4.8	4.8		5
6. The amount of time available for conducting all community planning is adequate.	4.4	4.4	4.5	4.2		5
7. The health department's HIV funds have been distributed fairly.	4.7	4.6	4.8	4.8		6
8. Given the time and money that has been put into the community planning in my jurisdiction, I am satisfied with what has been accomplished.	4.4	4.4	4.0	4.6		6

9. **Considering your answer to the previous question, please describe what you believe has made HIV prevention community planning in your area successful and/or problematic. Please indicate whether your comment is positive or negative. (Use the space below or back of sheet as necessary)**

- Due to the nature of our location, we have been given support and materials for us to use in our rural areas. However, being able to implement some of the outreach used in the city is blocked by our location and audience.
- More representation on CPG and all subcommittees.
- More involvement in sharing news and needs from local activities.
- The openness of the process, the make-up of the group; the cohesiveness; the clear set structure; the good orientation process; the organization and structures that the Health Department co-chair brings to the process; equal voice and vote of all members.
- The Committee is strongly committed to providing the best prevention programs for the State.
- We need more grants for outreach to Latinos in Northern Virginia. There is a big need of HIV information, especially for labor day workers.
- In most cases HIV prevention community planning is problematic because many of the other organizations/groups do not work with the ASO in my area when the ASO reaches out or wants to work with them.
- Negative – There needs to be more members from Northern Virginia, but that is not necessarily the CPG's fault.

Additional Comments and Questions:

- CPG is the most functional and productive committee I have know or been a part of in the past 14 years of my HIV work.
- Need to find ways for the sub-committees to be more productive.
- How can we use other members more effectively in leadership?
- Data regarding resources, unmet needs and needs assessments are somewhat limited as they are gathered from Health Department and CDC funded agencies and not agencies funded by other sources.
- We have become more successful with youth. How can we bring in other communities who should be at our table?
- How can we make the Profile more complete and demonstrative of Virginia's needs and more flexible for use in a variety of ways?
- How can we start discussing cost-effectiveness with connectedness to our priorities planning?
- We are making changes. How can we make the connection stronger between our planning process and better prevention in the Field?
- Not sure of the availability of CPG information (meeting summaries) to non-CPG members.
- I am fearful that all the good work will be for naught because the budget deficit and the cutting of funds for HIV prevention education and the HIV Resource Centers.
- The Epi profile is now much more accessible and better written.
- The true effectiveness of most prevention interventions is untested and unknown.
- VDH maximizes input from the CPG in its funding application and goes to great effort to make the application available to the CPG for review.
- I am a new member still learning about this committee's responsibilities. I am extremely proud of our group accomplishments in 2002 and look forward to a more successful 2003.
- The success of the CPG is largely due to Elaine Martin. She is an exceptional leader and is so well received by many diverse groups of people. She keeps the group moving and growing and focused. We could not have the outstanding CPG we have without her.

- As a newcomer to the Virginia Community Planning Group and a former San Francisco Health Program Coordinator, I am struck by the cooperation and "southern hospitality" of the group as well as the competence and vitality of all involved. I hope to be more participatory as time goes on. Thanks for inviting me to the party.
- Thank you and continue the good and strong team efforts!
- I think it is time for the CPG to really take a look at HIV/AIDS in the rural communities. I don't know if they don't want to address the issues of the rural communities or just don't know how.
- I enjoy working on HIV CPG. At one time it appeared that S.E.R.L. staff dominated and intimidated some which really inhibited team participation. However, since the absence of the S.E.R.L. staff on the Committee, the group has been able to accomplish more and move forward at a greater pace.
- Good group. Good work.
- Many members rely too much on guidance from the health department and do not proactively work to accomplish the necessary tasks to develop a plan. They wait for the health department to tell them what to do.
- The general membership needs to take more responsibility for the Committee.